103

Y 4.G 74/7:M 46/12

Medicaid Fraud, 103-2 Hearing...

MEDICAID FRAUD

HEARING

BEFORE THE

HUMAN RESOURCES AND INTERGOVERNMENTAL RELATIONS SUBCOMMITTEE

OF THE

COMMITTEE ON GOVERNMENT OPERATIONS HOUSE OF REPRESENTATIVES

ONE HUNDRED THIRD CONGRESS

SECOND SESSION

FEBRUARY 25, 1994

Printed for the use of the Committee on Government Operations

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ISBN 0-16-047240-7

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MEDICAID FRAUD

FRIDAY, FEBRUARY 25, 1994

HOUSE OF REPRESENTATIVES,
HUMAN RESOURCES AND
INTERGOVERNMENTAL RELATIONS SUBCOMMITTEE
OF THE COMMITTEE ON GOVERNMENT OPERATIONS,
Miami, FL.

The subcommittee met, pursuant to notice, at 10:01 a.m. in the city of Miami Commission Chambers, 3500 Pan American Drive, Miami, FL, Hon. Edolphus Towns (chairman of the subcommittee) presiding.

Present: Representatives Edolphus Towns, Steven Schiff, and John L. Mica.

Also present: Representative Carrie P. Meek.

Staff present: Ronald A. Stroman, staff director; Kristine Simmons, professional staff member, Martine M. DiCroce, clerk; and Martha B. Morgan, minority professional staff, Committee on Government Operations.

OPENING STATEMENT OF CHAIRMAN TOWNS

Mr. TOWNS. The Subcommittee on Human Resources and Intergovernmental Relations, Committee on Government Operations will come to order.

Today, the Human Resources and Intergovernmental Relations Subcommittee will examine Medicaid fraud. During the past decade, an unprecedented crime wave of $1 billion fraud has emerged within the Medicaid program. This fraud, includes organized networks of colluding doctors, pharmacists and middlemen. These so-called "pill mills" have victimized New York, Florida and every other State in the Nation.

In one variations of this scam, physicians operate out of store front offices, for the exclusive purpose of exploiting the Medicaid program. Physicians write unnecessary prescriptions and bill Medicaid for unnecessary tests. The pharmacist bills Medicaid for the filled prescriptions. The patient then sells the unneeded drugs to a middleman, who will re-sell the prescription back to the pharmacy.

GAO has concluded that many Medicaid agencies maintain inaccurate data, have no early warning system for the fraudulent billing patterns and are badly understaffed. There is often poor coordination between State and Federal enforcement efforts, and minimal oversight by the Department of Health and Human Services. Incredibly, many providers who have committed Medicaid fraud are still participating in the program.

Unlike some white collar crime, Medicaid fraud is not victimless. When inappropriate drugs are prescribed or appropriate medication is diverted, the health and safety of Medicaid patients is placed at risk.

Health care fraud is a major factor in the spiraling cost of health care. All of us pay for this fraud. An insurer passes the losses along to consumers by increasing health insurance premiums. State Medicaid officials have reported to GAO that fraud within the Medicaid program may have cost the Medicaid program $15 billion—that is "B" as in "boy"—in 1993. This fraud also helps keep 37 million Americans without any health insurance, from being able to get it.

The truth is that Medicaid fraud is being committed by highly sophisticated medical providers. The changes of being caught are slim. If caught, the chances of receiving any serious sanctions are even more remote. So that Medicaid fraud pays. We must change that equation and we must change it now.

In a report to this subcommittee in August 1993, GAO found that the Florida Medicaid Fraud Control Unit rejects more than 90 percent of referrals from the State Medicaid agency because of a lack of money. In addition, of nine people charged with Medicaid fraud—this is Florida—in 1990, five, including a pharmacist excluded from program participation, were employed in pharmacies that were Medicaid providers as of December 1992. This situation must change.

We need to develop an accurate Medicare data system. Federal, State and local agencies must find better ways of sharing information on fraud. We need more coordinated Federal and State fraud investigations, to make more efficient use of limited enforcement resources. We also need better oversight by the Health Care Financing Administration. Finally, we must insist that people convicted of this fraud be punished to the fullest extent of the law, including exclusion from participation in the Medicaid program, license revocation and where appropriate, prison and fines.

I believe we must strongly resist the greatly understaffed Medicaid investigation units. Without a comprehensive attack on these criminal enterprises, health care in this country will remain in critical condition.

At this time, I would like to yield to the gentleman from Albuquerque, NM, the ranking member of the committee, Mr. Schiff, for an opening statement.

Mr. SCHIFF. Thank you, Mr. Chairman.

Mr. Chairman, I have just a couple of remarks. The first is a sincere congratulations and thanks to you for continuing this series of hearings on the subject of Medicaid fraud. As I look at the subject and receive more and more information, the amount of money that the system is losing because of fraud is in staggering proportions. And as we look for ways to raise money to improve health care delivery in this country, regardless of what our philosophies might be on how that is best accomplished, I think it is clear to everybody that this money that is not available, that is being cheated from the system, would make an enormous difference toward improving what we could deliver if we had it available to us.

I want to, second of all, add that although I have some different approaches to the fight against crime generally than the Clinton

administration has, on this issue they have been outstanding. In the President's proposed budget for the Department of Justice for the next fiscal year that would begin on October 1, there is a heavy emphasis in the administration's proposal on increased prosecutions for welfare fraud.

And I think we should point out who we are talking about here. We are talking about fraud involving providers where the recipients, if involved, are involved as secondary characters to help the providers in their scheme. It should be emphasized that this is an extremely, extremely small percentage of providers, but providers, if they choose to be involved in fraud, can accomplish more fraud than recipients can. If you are a recipient of Medicaid fraud, how many prescriptions can you say you need or how many children can you say you have and how many teeth can you say need filled. Your provider, on the other hand, has an almost limitless way of making claims against the government. So the financial damage that a provider can do is much more than 20 recipients can do even if they intend to commit fraud.

And I would take the matter one step further than the administration. I would suggest that where the U.S. Government has seen fit to set up an entitlement program, meaning a program where there is not a fixed number of recipients, there is a category of recipients that could increase with time, that the funding for those who investigate and prosecute fraud in that area should also be funded as an entitlement program. I think the way we are doing it now, and that is, we are spending more on the entitlement program but we are restricting the number of investigators and prosecutors because they come on a line item basis, is an absolute invitation to financial fraud. And I think the people who commit this fraud have seen that opportunity. And I believe that—it is unfortunate that I have to say this, Mr. Chairman, but I think that every time we hire an additional fraud investigator, they more than pay for themselves in savings. And I wish the system were more perfect, but obviously it is not.

I would finally say that I want to express my appreciation for your holding this hearing in the State of Florida. That was on my recommendation that you accepted because our colleague, who will speak next, John Mica, has become a leader on this issue among the new Members of Congress and has worked diligently, has attended all the hearings, has made significant contributions, and I very much appreciate the fact and I want to let everyone who is here know this, that although we sit, back in Washington—we sit on different sides of the aisle, you have never permitted that sides of the aisle mentality to exist in this subcommittee and you have welcomed the full participation of all the Members and we have tried to deliver that participation. And I want to express my appreciation.

But we are here in Florida in particular today because of the work that one of Florida's representatives has done on this issue. And I would like to yield, with your permission, to Congressman Mica at this time.

Mr. MICA. Thank you, Congressman Schiff——

Mr. TOWNS. Thank you very much. And let me just—I would like to thank the gentleman for his kind remarks and to also associate

myself with the remarks in terms of Congressman Mica. You are right, he has been at every hearing and has said very loud and in a very clear voice that if we are going to reform health care, we have to first root out fraud, and without rooting out fraud, that whatever we are doing, we cannot be but so successful unless we address this issue. So I would like to commend him for the kind of work that he has done in this regard and to say to him we also appreciate the work that you are doing on this committee as well. Thank you.

Mr. MICA. Thank you, Mr. Chairman, and thank you, Mr. Schiff for your remarks.

First of all, I do want to welcome you to Florida. This is not my district but your mission here today is very important, and let me say too that what you are doing is some of the meat and potato work of Congress, and in particular on this issue, bringing to the attention of the Congress and also to the representatives and some of the people involved in Medicaid in the State of Florida, the issue of Medicaid fraud.

I quite frankly was shocked when we saw the results of the GAO study that was released August 2, 1993, in which Florida was named as actually one of the States most prominent and with one of the most critical fraud abuse problems in the Nation in the area of Medicaid fraud. There are $6.4 billion spent on Medicaid in Florida and some of the reports we will see estimate—a very conservative estimate is that 10 percent of that money goes to fraud, waste and abuse. So we are talking about three quarters—close to three quarters of $1 billion in a fairly conservative estimate that has the potentials just sort of flying out the door in fraud. So it is a very serious problem in the State of Florida.

It is also timely that you are here in that Florida is looking at some solutions to replacing its current health care system, not only at the national level, as you know, we are actively engaged in that, but Florida is right at the beginning stages. So whatever plans we adopt in the State or at the national level, it is critical that we do this with efficiency and also sort of cleaning up our act, so to speak, in the fraud in the public arena.

Let me say also, I commend you that if nothing else comes other than the results of this hearing and the hearing that was held August 2, you have already begun the process in Florida. We brought this matter to the attention of the Governor, the cabinet and the legislative leaders. I met with them again in Tallahassee this past week. They are pursuing several avenues as a result of, again, your process. First, I understand we are going to move—in talking to the Attorney General, Mr. Butterworth—the Medicaid fraud activities, pursuit of Medicaid fraud from an auditing function into the Attorney General's Office. It appears also that we have a task force that has been looking at trying to make corrections. We will hear more about that in testimony, but what you have already done has made progress in a positive direction, which will save taxpayers of this State tens of millions of dollars.

So I first of all congratulate you on coming here and calling more attention to the problem and also for the corrective measures which you have instituted. So again, I salute you and welcome you and look forward to the testimony we are about to hear here today.

Mr. SCHIFF. Could I ask for your indulgence for one more word, Mr. Chairman?

Mr. TOWNS. Sure.

Mr. SCHIFF. I want to go to the issue of prosecution and punishment for those convicted of welfare fraud. There is a beating crescendo in this country that to relieve prison overcrowding, which is admittedly a problem, we should not put in prison—or release from prison in fact—first time, nonviolent offenders. And I want to stress—and I was a career criminal prosecutor as well as a defense attorney before—in a previous life before I got to Congress—so I certainly believe as a general philosophy that we should look for alternatives to prison for those who commit offenses, particularly if they are young, particularly if their offenses are relatively minor.

But I think the blanket statement about first-time nonviolent offenders includes those people who might be convicted of bilking the system out of millions of dollars in a program like this. And I think that when we look at the cost of incarceration, which rounds out to somewhere between $20,000 and $25,000 per year, from an economic point of view, we need to look at some of the damage some of these so-called first-time, nonviolent offenders are inflicting on the system, because I think that the deterrence that stronger punishment would have in this area would pay for those incarcerations if they occur.

Thank you, Mr. Chairman, I yield back.

Mr. TOWNS. I would thank both the gentlemen for their statement; the gentleman from Florida as well as the gentleman from New Mexico.

At this time we would like to call our witnesses. Our first panel of witnesses this morning are Leslie Aronovitz, Associate Director of the Human Resources Division of the General Accounting Office; Rufus Noble, Inspector General, Florida Agency for Health Care Administration, and Mr. Noble is accompanied by John Whiddon, the chief of the Medicaid Program Integrity Unit. Finally we have John Morris, director of the Florida Medicaid Fraud Control Unit.

I would like to welcome you all to the subcommittee. We have your prepared testimony, which without every objection, every "I", every "T", every everything will go into the record.

Mr. SCHIFF. Pardon me, Mr. Chairman, if I may ask you to yield for a moment.

Mr. TOWNS. Sure.

Mr. SCHIFF. There is a message in that.

Mr. TOWNS. So please summarize—thank you—please summarize your testimony within 5 minutes so that the Members will have time to ask questions.

Mr. Aronovitz, it is a pleasure to have you back before the subcommittee again. Please proceed to summarize your statement. Why do we not begin with you.

STATEMENT OF LESLIE G. ARONOVITZ, ASSOCIATE DIRECTOR, HUMAN RESOURCES DIVISION, GENERAL ACCOUNTING OFFICE

Ms. ARONOVITZ. Thank you.

Mr. Chairman and members of the subcommittee, I am pleased to be here this morning to discuss the problem of fraud in the Med-

icaid program. As you know, Medicaid is the largest government health program for the poor. In 1993, the program expenditures exceeded $150 billion. Fraud in this program is widespread. The ensuing drain on public funds is hard to estimate, but as Mr. Mica said, officials estimate this conservatively as 10 percent of total program expenditures.

My comments today draw heavily on our findings from a recent investigation which we conducted at your request, that focused on the diversion of prescription drugs paid for with Medicaid funds. Although we performed our work in a number of States, we found that the problems associated with Medicaid fraud nationwide are equally or more pervasive in Florida. But Florida is also one of the most aggressive States in attempting to reduce Medicaid fraud. And many things have occurred in Florida since our last testimony in New York, that show a very strong sign of trying to get a handle on the problem.

Drug diversion is a type of fraud which is lucrative, widespread and difficult to control. We found that some pharmacists routinely added medications to customers' orders, keeping the extras to use themselves or selling them over the counter pill-by-pill. Clinics inappropriately provided Medicaid recipients with completed prescription forms called scrips, that recipients then sold on the street to the highest bidder. In one instance in Houston, pills costing 50 cents at a pharmacy were resold on the street for $85. Prescription drug diversion frequently occurs in conjunction with other fraudulent schemes. Our analysis of Medicaid claims data in New York showed one typical example. Using the Medicaid number of one recipient during an 18-day period, providers billed more than $3,000 for office visits, 85 prescriptions and the same three lab tests performed at five different labs.

Fraud, and drug diversion in particular, persist for a variety of reasons. These include incomplete and unreliable data available for identifying possible fraud, ineffective use of data to detect aberrant providers, inadequate resources at the investigative and prosecutorial levels, a complex administrative structure that requires extensive coordination, light penalties for convicted offenders, and poor follow up of their subsequent involvement in the health care system.

Mr. Towns, you alluded to some examples that we found in our study where individuals who were convicted—excuse me, charged with drug diversion, were actually able to continue to participate in the Medicaid program, either by opening up pharmacies in spouses' names or using a different form of their own name, or because the system had not caught up with them and the system did not realize that they had been thrown out of the Medicaid program or charged with Medicaid fraud.

Faced with such problems on following up on crimes within their own borders, it is not surprising that State officials cannot prevent incursion by offenders from out-of-State. Our investigation found that several providers in New York, suspected or convicted of fraud, were associated with Florida health care facilities. We know of one case where a clinical lab and a nursing home in Florida reportedly receiving Medicare and Medicaid funds are owned by felons who were convicted in New York.

So the question remains, how can this activity be combated. Florida has already instituted several prevention measures—had already at the time we did our study, which was last summer—and they have done a lot of new things since that I will mention briefly. Prescriptions in Florida are limited to six per month, to control utilization. A pilot program is underway for on-line eligibility verification and the State Medicaid bureau has enhanced its analytical capability to target suspect physicians and pharmacies. Florida's Medicaid Fraud Control Unit, MFCU has also supported the use of Medicaid photo ID cards, an approach already adopted in New York and some other States.

In regard to pursuit and punishment, Florida has set up an interagency task force addressing Medicaid fraud in all three of its Federal court districts, and penalties have been strengthened. Mandated professional sanctions include immediate license suspension for physicians convicted of a felony, although we could elaborate on that and say that the system is still not air tight. An assistant U.S. attorney in south Florida is dedicated to Medicaid fraud and supports a new 10-person FBI task force on health care fraud. Alternatively, the authorities can bypass the criminal pursuit process through innovative administrative remedies, such as Florida's guidelines and sanctions matrix, which is now part of State law.

Recovery of program losses is also receiving more attention. Florida's MFCU officials favor requiring high-volume providers to post performance bonds or other types of collateral as a condition of participation. This is a very common occurrence in some other States and it is adopted in New York and on a smaller scale elsewhere. The Florida Legislature has also approved a supplemental appropriation to substantially increase staff resources for pursuing aberrant Medicaid providers. And the State has made changes that transferred these responsibilities to the Inspector General, as of July of last year.

Although hard evidence of the success of prevention and detection measures and harsher sanctions is generally lacking, there is consensus that a combination of initiatives in New York has reduced the number of Medicaid prescription claims 8 percent in the last few years, and Medicaid spending in other parts of the program are also being reduced.

Let me say one thing about managed care, which is an initiative that is occurring in Florida along with other States. Many fraud schemes arise from a fee-for-service based system where providers have an incentive to overserve or to bill for more services than were provided. Nearly all States are responding by establishing managed care programs for their Medicaid recipients. Managed care is a health delivery care system that uses primary care physicians to provide or arrange for the health care in a cost conscious manner.

I am not going to elaborate in my oral statement, but there are other types of concerns that you need to worry about when you established a managed care system, because now the incentives change from overserving and billing for services not provided, to what I would call a more insidious problem, and that is underservice or trying to maximize your profit by not providing ap-

propriate medical services. So you need quality and financial oversight mechanisms to assure that underservice does not occur.

So in summary, while all jurisdictions have severe resource constraints that limit oversight, investigative and prosecutorial efforts, we feel that an absence of Federal leadership has kept States from making the best use of the resources they have. For this reason, last summer, we recommended that the Administrator of the Health Care Financing Administration develop an overall strategy to address Medicaid fraud, including evaluating existing State initiatives and sharing best practices and providing guidance and technical assistance tailored to individual State problems.

Mr. Chairman, this concludes my statement. I would be happy to answer any questions, if you have any later.

[NOTE.—To reduce publication costs, the subcommittee has omitted from the record a report entitled, "Medicaid Drug Fraud, Federal Leadership Needed to Reduce Program Vulnerabilities," GAO/HRD–93–118. A copy of the report may be found in subcommittee files.]

[The prepared statement of Ms. Aronovitz follows:]

United States General Accounting Office

GAO

Testimony

Before the Subcommittee on Human Resources and Intergovernmental Relations, Committee on Government Operations, House of Representatives

For Release on Delivery
Expected at
10:00 a.m., EST
Friday
February 25, 1994

MEDICAID

A Program Highly Vulnerable to Fraud

Statement of Leslie G. Aronovitz
Associate Director, Health Financing Issues
Health, Education, and Human Services Division

GAO/T-HEHS-94-106

SUMMARY

The Medicaid program cost state and federal governments over $150 billion in 1993 for health services and supplies. It is highly vulnerable to fraud because of its size, structure, target population, and coverage. The ensuing drain on program funds is difficult to gauge, but state Medicaid officials believe it can be as high as 10 percent of program expenditures.

Prescription drugs--one of Medicaid's covered services--are one appealing target. Diversion of these drugs is lucrative, widespread, and difficult to control. Schemes include pharmacists routinely adding medications to customers' orders and clinics inappropriately providing Medicaid recipients with completed prescription forms, or scrips, that may be sold on the street to the highest bidder. Some pills costing 50 cents at the pharmacy have been resold for as much as $85. In Florida, some pharmacies have also accepted the scrips in exchange for lottery tickets, TV sets, and even a grandfather clock. The drugs--for which the pharmacy billed Medicaid as though they had been dispensed to the recipient--may have been shipped to Cuba.

Medicaid drug diversion frequently occurs in conjunction with other fraud involving clinics and labs. For example, one group of providers billed Medicaid more than $3,000 for office visits, 85 prescriptions, and the same three lab tests five times, for the same recipient over one 18-day period.

States are addressing the problem of Medicaid fraud and meeting with some success. Recent initiatives focusing on prevention or early detection include the use of improved identification and utilization monitoring procedures and prescription-filing systems that can instantly link orders to the filing physician. To enhance pursuit and punishment of offenders, interagency task forces now target health care fraud, and harsher sanctions have been approved. Introduction of managed care for Medicaid recipients also offers some promise of decreasing fraud related to overbilling or provision of unnecessary services.

Nevertheless, the problem persists. Officials in many states told us that most leads are not pursued, cases take too long to resolve, and penalties are light even for those convicted. Most say that lack of adequate resources limits oversight, investigative, and prosecutorial efforts. We feel that a lack of federal leadership has kept states from making the best use of the resources they do have. The Health Care Financing Administration should develop an overall strategy to address Medicaid fraud and provide guidance and technical assistance to the states struggling to control these schemes.

Mr. Chairman and Members of the Subcommittee:

I am pleased to be here this morning to discuss fraud in the Medicaid program. My comments draw heavily on findings from our recent investigation--conducted at your request--that focused on the diversion of prescription drugs paid for with Medicaid funds. Although we reviewed cases of such diversion and associated types of fraud in a number of states,[1] we found that the problems associated with Medicaid fraud nationwide are equally, if not more, pervasive in Florida.

MEDICAID IS VULNERABLE TO FRAUD AND ABUSE

As you know, Medicaid is the largest government health program for the poor. The Health Care Financing Administration (HCFA) in the Department of Health and Human Services (HHS) estimates that 1993 program expenditures for health care services and supplies exceeded $150 billion on behalf of almost 32 million recipients. Medicaid's size, structure, target population, and coverage make it highly vulnerable to false billings and other fraudulent activities.

Program Size and Structure Contribute to its Vulnerability

Medicaid is a federally aided, state-administered medical assistance program.[2] The federal government provides a share of each state's payment for services--between 50 and nearly 80 percent--depending on the state's per capita income.

Several characteristics of Medicaid's structure invite fraud:

-- It is a large program, with costs anticipated to reach $161 billion in 1994. It generates a correspondingly large number of provider claims, which creates difficulty in examining them closely for abusive practices.

-- Eligibility is income-dependent and thus constantly changing. Many states, including Florida, issue their Medicaid recipient ID cards monthly. This complicates verifying who is eligible and for what services as well as controlling the possession and use of Medicaid cards.

-- Providers are often in short supply, and program administrators do not want to discourage participation by imposing controls that could be perceived as unduly burdensome.

-- Because it has traditionally been a fee-for-service system, with nominal if any significant copayments, Medicaid offers no financial disincentives to heavy use by honest recipients, much less those who may participate in dubious schemes.

Medicaid fraud is widespread. The ensuing drain on program funds is hard to estimate, but state officials believe the loss is significant, perhaps as high as 10 percent of total program expenditures.

Such fraud frequently involves providers that bill for services not rendered or not medically necessary. Schemes take many forms. A snapshot of recent cases is provided in table 1.

Table 1: Examples of Recent Medicaid Fraud Cases

A Minnesota dentist was charged with defrauding Medicaid over a 4-year period by billing for services to nursing home residents who were already dead or who were absent from the nursing home at the time he claimed to treat them there. Cost to Medicaid: $25,242	A Massachusetts physician was indicted for submitting fraudulent bills to Medicaid, claiming to have treated patients with fractured bones and other injuries never sustained. Cost to Medicaid: $30,000
The owner of a New York nursing home, himself a former federal prosecutor, was convicted of inflating construction and operating costs to improperly obtain increased Medicaid reimbursement. Cost to Medicaid: $1,173,694	A psychiatrist in Harlem was convicted of illegally selling prescriptions on demand for cash. Over an 18-month period, he may have pocketed over $1.2 million in cash from his patients. Pharmacies billed the prescriptions to Medicaid. Cost to Medicaid: $1.8 million

PRESCRIPTION DRUGS ARE ONE TARGET OF FRAUD

In studying Medicaid fraud, we focused on the diversion of prescription drugs. This type of fraud, which involves diversion of drugs paid for by Medicaid, is lucrative, widespread, and difficult to control. Some drugs have psychological or physical effects similar to those of illicit drugs, and others have substantial monetary value. When Medicaid pays for the prescriptions, profiteers can divert them for resale through illicit channels.

We found that some pharmacists routinely added medications to customers' orders, keeping the extras to use themselves or to sell to others. Clinics inappropriately provided Medicaid recipients with completed prescription forms, called scrips, that recipients

then sold on the street to the highest bidder. Some pills costing 50 cents at the pharmacy were resold for as much as $85.

Florida law enforcement officials described to us one type of scheme particularly prevalent in Miami and probably also in Tampa. This involved Medicaid recipients who obtained scrips on demand from obliging doctors. Pharmacies colluding in the scheme gave store credit for some percentage of the scrip's value. Examples of merchandise obtained in this manner included tennis shoes, TV sets, toaster ovens, and a grandfather clock. In some cases the scrips were even exchanged for lottery tickets or the payment of utility bills. The pharmacy billed Medicaid for the drugs, some of which may have been shipped to Cuba, others sold over the counter on demand, one pill at a time. Investigators told us that they believe such schemes persist, with some pharmacies billing Medicaid for more than $1 million a year--50 percent of which may be fraudulent.

Prescription drug diversion frequently occurs in conjunction with other fraudulent schemes. Our analysis of Medicaid claims data in New York revealed one typical example involving a recipient who was the subject of considerable billing activity by a group of suspect providers. Using the Medicaid number of one recipient, for one 18-day period, providers billed Medicaid more than $3,000 for office visits and associated claims for 85 prescriptions and the same three lab tests five times.

WHY ABUSES PERSIST

Drug diversion in the Medicaid program persists for a variety of reasons. These include ineffective use of data, inadequate resources, and a complex administrative structure, as well as light penalties for convicted offenders, and poor follow-up of their subsequent involvement in the health care system.

Data to Detect Fraud Are Not Effectively Used

State Medicaid agencies have paid claims data and other records that can be used to identify patterns of fraud, abuse, gross overuse, or inappropriate or medically unnecessary care. However, we found that, due in large part to the unreliable and incomplete nature of these data, state Medicaid agencies generally do not rely on analyses of their data to identify potential drug diversion. Instead, we found that most alleged abuses investigated by the Medicaid Fraud Control Units (MFCUs) are identified through tips or other fortuitous means. Others are referred by the Medicaid agency, but even those are seldom revealed by routine analysis of existing claims data.

In California, we found that a pharmacist was billing and being reimbursed by Medicaid for dispensing large volumes of drugs. For 3 years the volume of prescriptions was improbably high--in many

cases more than 20 prescriptions a day for a single recipient. The state's reporting system, however, did not trigger an investigation of the pharmacist nor of any of the recipients. A tip ultimately revealed the scheme.

Resources Are Inadequate

State law enforcement and program officials that we talked to expressed a belief that far more potentially fraudulent offenses were occurring than they had the resources to pursue. Florida's Medicaid agency estimates that 90 percent of its referrals are rejected by the MFCU for lack of resources. Even when cases are opened, preparing them for prosecution is slow and resource intensive.

Our own analysis of Florida drug diversion cases leading to conviction revealed that, from the time they were reported to the MFCU, half of the cases took almost 3 years (32 months) before offenders were excluded from Medicaid and more than 5 years (62 months) before professional licensure action--if any--was completed. None of the cases we reviewed resulted in more than a 1-year probation. Sixty percent led to no action by the cognizant state licensing agency.

Complex Administrative Structures Result in Need for Extensive Coordination

It is not unusual for a drug diversion case to involve five or more state, local, and federal agencies in its investigation, prosecution, and resolution. In a case of provider abuse, state Medicaid agencies are authorized to take certain administrative actions. When fraud or some other form of intentional wrongdoing is suspected, cases in most states are referred for investigation to the organizationally separate MFCUs.

At the federal level, HCFA funds and oversees the Medicaid program. However, no organizational unit within HCFA is dedicated to curbing fraud and abuse, and HCFA is not directly involved in drug diversion cases.

Financial and Other Penalties Are Light

To compensate for limited resources, many cases are settled short of conviction. Plea bargaining is common, and most first offenders in Florida are subject to "pretrial diversion," in which their court records are sealed if they abide by the terms of judicially approved probation for 1 year.

With regard to financial penalties, in more than half the cases we reviewed across the four states, restitution amounts were nominal--$5,000 or less. Providers usually paid these amounts. But in cases in which courts set restitution at $20,000 or more, the

Medicaid agency recovered only a small percentage of the dollar amount established. In one Florida case in which restitution was set at $220,000 on March 5, 1991, only $4,000 had been repaid as of the close of our inquiry on July 12, 1993.[3]

Little Follow-up of Convicted Providers

Providers convicted of Medicaid fraud are generally excluded from the program. However, offenders frequently retain some connection with health care delivery and have subsequent opportunities to commit further violations. Although federal laws are in place to exclude previously convicted providers from program participation, it appears that no one with authority and adequate resources is following up on these individuals. In the Florida cases we reviewed, we found that

-- of nine individuals charged with Medicaid fraud in 1990, five--including a pharmacist excluded from program participation--were employed (as of July 1992) in pharmacies that served Medicaid recipients, and

-- of five pharmacies charged with fraud in 1990, three were excluded from Medicaid participation. One pharmacist-owner sold his store but is still employed there as a pharmacist, and the other two re-enrolled in Medicaid under new ownership. One of the new owners is married to the convicted former owner.[4]

Faced with such problems in following up on crimes within their own borders, it is not surprising that state officials cannot prevent incursion by offenders from out of state. Our investigation found that several providers in New York, suspected or convicted of fraud, were associated with Florida health care facilities: a clinical lab, and a nursing home that reportedly receives both Medicare and Medicaid funds.

STATE EFFORTS ARE MEETING WITH SOME SUCCESS

States have some systematic controls designed to prevent drug diversion and other types of Medicaid fraud. Some are also establishing new initiatives that hold promise in curbing fraud. Since even the best controls are never 100-percent effective, states also have procedures for pursuit, punishment, and financial recovery.

Prevention and Early Detection Are a High Priority

Advanced identification technology and automated systems that can flag suspicious activity can prevent or detect fraud early on. Recent initiatives in some states include the use of identification cards that resemble credit cards and monitor utilization, prescription-filing systems that can instantly link orders to the filing physician, and data analysis techniques that can promptly

identify physicians and patients prescribing and receiving high volumes of drugs.

Florida had already instituted several such measures at the time we did our field work: prescriptions were limited to six per month; a pilot program was under way for on-line eligibility verification; and the state Medicaid bureau had enhanced its analytical capability to target suspect physicians and pharmacies. Florida's MFCU also supported the use of Medicaid photo ID cards, an approach already adopted in parts of New York state.

Other Initiatives Focus on Pursuit and Punishment

One approach to swifter and more certain pursuit of offenders uses multiagency task forces to coordinate case development. In Florida, interagency task forces addressing Medicaid fraud exist in all three federal court districts, and penalties have been strengthened. Mandated professional sanctions include immediate license suspension for physicians convicted of a felony. An assistant U.S. attorney in South Florida is dedicated to Medicaid fraud and supports a new 10-person Federal Bureau of Investigation task force on health care fraud. Alternatively, the authorities can bypass the criminal pursuit process through innovative administrative remedies such as Florida's guidelines and sanctions matrix, now part of state law.

Recovery of program losses is also receiving more attention. Stronger tools are available, such as requiring certain high-volume providers to post performance bonds or other forms of collateral as a condition of program participation.[5] Florida's MFCU officials favor such an approach, already adopted in New York and, on a smaller scale, elsewhere. Subsequent to our study, Florida demonstrated its confidence in the cost effectiveness of spending money to recover even more: the legislature approved a supplemental appropriation to substantially increase staff resources for pursuing aberrant Medicaid providers. Florida also made changes that transferred these responsibilities to the Inspector General as of July 1993.

Although hard evidence of the success of prevention and detection measures and harsher sanctions is generally lacking, encouraging signs exist. For example, a combination of initiatives in New York is associated with an 8-percent decrease in the number of Medicaid prescription claims during the past 5 years and a sharp reduction in spending for the most abused drugs.

Structural Changes Hold Promise

Many fraud schemes arise from a fee-for-service based system, which has an incentive to overserve or to bill for more services than are provided. Nearly all states are responding to this incentive, spiraling program costs, and problems of poor access by

establishing a different structure for health care delivery--managed care approaches that use primary care physicians to provide, or arrange for, health care in a cost-conscious manner.

Last year, to review states' efforts to implement managed care, we performed a nationwide survey of state Medicaid programs and detailed work in six states.[6] Our work did not focus specifically on the success of Medicaid managed care initiatives in preventing and detecting program fraud. However, Medicaid experts told us that managed care programs substantially discourage both provider and recipient fraud schemes often found in fee-for-service Medicaid.

CONCLUSIONS

Many of the problems we found result from ineffective use of data, complex administrative structures, inadequate financial and other penalties, and poor follow-up of convicted providers. While all jurisdictions have severe resource constraints that limit oversight, investigative, and prosecutorial efforts, an absence of federal leadership has kept states from making the best use of the resources they do have. For this reason, we have recommended that the Administrator of HCFA develop an overall strategy to address Medicaid fraud. This strategy should include evaluating existing state initiatives and providing guidance and technical assistance tailored to individual state problems.

Mr. Chairman, this concludes my statement. I would be happy to answer any questions you may have.

NOTES

1. We performed our field work in California, Florida, New York and Texas, and spoke with law enforcement officials in the majority of states.

2. Medicaid was established under the 1965 amendments to title XIX of the Social Security Act (42 U.S.C. 1396-1396u).

3. This came to light as a result of our case review. State Medicaid officials and court probation officers said they lacked sufficient personnel to keep track of payments due.

4. When GAO brought these situations to the attention of Florida Medicaid officials, they said that either they were not aware of their status or they had not yet determined whether terms of exclusion had been violated. Under some circumstances, an excluded individual may be connected with a participating facility in a limited capacity.

5. In New York, where this approach has been adopted, a high-volume provider is defined as one with anticipated Medicaid billings exceeding $500,000 a year.

6. The six states were Arizona, Kentucky, Michigan, Minnesota, New York, and Oregon.

(101303)

Mr. TOWNS. Thank you very much, Ms. Aronovitz.
Mr. Noble.

STATEMENT OF RUFUS D. NOBLE, INSPECTOR GENERAL, FLORIDA AGENCY FOR HEALTH CARE ADMINISTRATION

Mr. NOBLE. Thank you, Mr. Chairman, members of the committee. Thank you for the opportunity to appear before you today to discuss Medicaid problems. As Inspector General of the Agency for Health Care Administration, I am responsible for ensuring accountability, integrity and efficiency in programs of the agency. We are a new agency, created by the Florida Legislature in 1992 to plan and coordinate Florida's health care reform efforts. As of July 1993, we assumed responsibility for the State Medicaid programs.

One of the programs that I supervise is Medicaid Program Integrity. The overall goal of program integrity is to reduce Medicaid fraud and abuse to the lowest possible level. Program integrity is an audit arm of the Medicaid program charged with deterring, detecting and generally dealing with fraud and abuse. We conduct audits, investigations, initiate recoveries of overpayments, apply administrative sanctions to providers when warranted, and refer providers to other agencies. This includes referrals of cases of suspected fraud to the Medicaid Fraud Control Unit.

Medicaid Program Integrity was established in January 1980. In the 14 years since, we have completed more than 17,000 audits, recovered over $40 million in overpayments, sanctioned more than 400 providers and referred over 1,000 providers to the Medicaid Fraud Control Unit for criminal investigation.

The Florida Medicaid program represents approximately 20 percent of the expenditures in the Medicaid programs in the eight States in the Southeastern Region of the Department of Health and Human Services. In the last 5 years, Florida program integrity accounted for 58 percent of the total overpayments collected and 41 percent of the total referrals for fraud investigation in that region.

Program integrity has developed and placed into operation advanced computer-based detection and auditing methods. Notwithstanding these methods, each provider for whom overpayments are sought or to whom sanctions are applied must be dealt with one-by-one. Each action must be susceptible to successful defense and each provider must be afforded opportunity of a hearing under the provisions of chapter 120 of the statutes.

Program integrity recoupment efforts have proven to be cost effective. Auditing and investigative capabilities have been limited only by resources. However, last year, Governor Chiles recommended, and the Florida Legislature appropriated 49 new positions as the first phase in our war on fraud and abuse.

Medicaid, like any other third party payer, is susceptible to fraudulent and abusive practices. Many persons involved in Medicaid in the Federal Government and State governments have estimated the extent of Medicaid. One of the most common estimates is the 10 percent that has been quoted here earlier. Florida Medicaid services budget of about $6.4 billion this fiscal year, a 10 percent abuse rate would represent a significant waste.

What I would like to talk about a little now is in general fraud and abuse in the health care industry. Within the State of Florida,

we passed the Health Care and Insurance Reform Act of 1993, required the Agency for Health Care Administration to establish a work group to conduct a study of health care fraud and abuse. Part of that, Mr. Mica referred to earlier. A number of recommendations have come out of that work group and they have been published in our Florida health security plan—health homes of 1994.

One of the areas that was touched on was fraud and abuse and managed care. As has been said earlier, the health care movement in Florida and at the national level is based to a great extent on managed competition strategy, including greater reliances on managed care. One of the main concerns there is quality of care problems that may occur more frequently in managed care than in traditional fee-for-service programs. As we move toward greater reliance on managed care, fraud and abuse detection methods must be adapted to that changing incentive system.

Some of the initiatives that we have identified to counter fraud and abuse—we have been using the Federal False Claims Act. The State of Florida does not have such an act in place right now; however, our Attorney General has drafted legislation to enact a False Claims Act in the State of Florida modeled after the Federal act. We feel that a False Claims Act, if enacted, would significantly improve our ability to detect and prosecute fraudulent health care providers.

In 1990, Governor Chiles met with then Attorney General Barr to initiate the health care fraud and abuse task forces in each of the three Federal districts. Those efforts have demonstrated tremendous preliminary results and we feel that they should be expanded.

The Agency for Health Care Administration has also proposed legislation this session to further strengthen Medicaid Program Integrity statutes. Emphasis is being placed on providing the resources to avoid payments of public funds to abusive providers, cutting off the faucet earlier and imposing greater civil penalties and administrative sanctions. Measures are also proposed to make it more difficult for bad providers to enter the program.

We recognize also that even though these collaborative efforts among agencies have been improved, there is great need to continue that process and we feel that by sharing of information more agencies will be able to detect fraud earlier, stop it earlier and take advantage of all those resources.

In closing, Mr. Chairman, we feel that one of the main things in terms of the national reform efforts and the State reform efforts, emphasis at the national level that would improve Federal regulations, stiffening sanctions and penalties against providers would greatly enhance our efforts at the State level.

Thank you.

[The prepared statement of Mr. Noble follows:]

TESTIMONY
RUFUS D. NOBLE, INSPECTOR GENERAL
FLORIDA AGENCY FOR HEALTH CARE ADMINISTRATION
MEDICAID FRAUD AND ABUSE

FOR

CONGRESS OF THE UNITED STATES
HOUSE COMMITTEE ON GOVERNMENTAL OPERATIONS
SUBCOMMITTEE ON HUMAN RESOURCES AND
INTERGOVERNMENTAL RELATIONS
EDOLPHUS TOWNES, CHAIRMAN

FEBRUARY 25, 1994
MIAMI CITY COMMISSION CHAMBER
3500 PAN AMERICAN DRIVE
MIAMI, FLORIDA

Medicaid Fraud and Abuse
Rufus D. Noble, Inspector General
Agency for Health Care Administration

Introduction

Mr. Chairman, Members of the Committee:

Thank you for the opportunity to appear before you today to discuss Medicaid Fraud and abuse. As Inspector General of the Agency for Health Care Administration I have the responsibility to ensure accountability, integrity and efficiency in programs of the agency. We are a new agency, created by the Florida Legislature in 1992, to plan and coordinate Florida's health care reform efforts. The agency is working to ensure that all Floridians have access to affordable, quality health care services.

MEDICAID PROGRAM INTEGRITY

One of the functions that I supervise is Medicaid program integrity. The overall goal of program integrity is to reduce Medciaid fraud and abuse to the lowest possible level. Fraud refers to the deliberate effort to obtain benefits to which a provider or recipient is not entitled. The term abuse means a non-criminal action that results in a provider being paid more than that to which they are entitled, including misutilization of Medicaid services without demonstrated intent to defraud.

The Medicaid program integrity organizational unit is an audit arm of Medicaid. It is charged with the responsibility of deterring, detecting and dealing with fraud and abuse. The unit conducts audits and investigations, initiates recovery of any overpayments, applies administrative sanctions to providers when warranted, and refers providers to other agencies. This includes referrals of cases of suspected fraud to the Medicaid Fraud Control Unit in the Office of the Auditor General for full-scale criminal investigation.

Medicaid program integrity was established in January 1980. In the fourteen years since, program integrity has completed more than 17,000 audits, recovered over $40 million in overpayments, sanctioned more than 400 providers, and referred over 1000 providers to Medicaid Fraud Control Unit for criminal investigation.

In 1993, Medicaid program integrity completed 1712 audits, recovered $8.4 million in cash, referred 70 providers to the fraud control unit, and sanctioned 68 providers with fines and exclusions. Recoveries per auditor have increased from about $150,000 annually in calendar year 1989 to $300,000 in 1993.

The Florida Medicaid program represents approximately 20 percent in expenditures of all the Medicaid programs of the eight states in the Southeastern Region of the Department of Health and Human Services. In the last five years, Florida Medicaid program integrity accounted for 58 percent of the total overpayments collected and 41 percent of the total referrals for fraud investigation in the Southeastern Region.

Program integrity functions include detection, professional review, utilization review, provider audit and preliminary criminal investigations. Program integrity has developed and placed into operation advanced computer-based detection and auditing methods. Notwithstanding these methods, providers from whom overpayments are sought or to whom sanctions are applied must be dealt with one by one. Each action must be taken carefully and each provider must be treated courteously. Each action must be susceptible to successful defense and each provider must be afforded the opportunity of a hearing under the provisions of Chapter 120, Florida Statutes.

Program integrity recoupment efforts have proven to be cost effective. Auditing and investigative capabilities have been limited only by resources. However, last year, Governor Chiles recommended, and the Florida Legislature appropriated 49 new positions as the first phase in fighting the war on fraud and abuse.

Fraud and Abuse in Medicaid

Medicaid, like other third party payers, is susceptible to fraudulent and abusive practices by providers. Many persons involved with Medicaid in the federal government and in state governments have provided estimates of the extent of fraud and abuse in Medicaid nationally and in individual states. Since it is not possible to measure, except inferentially, something that has not been detected, those estimates are approximations based on experience with fraud and abuse that has been found.

Almost all of these estimates place Medicaid fraud and abuse at from five to fifteen percent of services expenditures, with ten percent being the most common proportion. With the Florida Medicaid services budget of about $6.4 billion this fiscal year, a ten percent fraud and abuse rate would represent significant waste.

FRAUD AND ABUSE IN THE HEALTH CARE INDUSTRY

The Florida "Health Care and Insurance Reform Act" of 1993, required the Agency for Health Care Administration to establish a workgroup to conduct a study of health care fraud and abuse. The findings and recommendations from the study are a part of our comprehensive health care reform plan - "The Florida Health Security Plan - Healthy Homes 1994". Next, I will talk about some of the major findings of the workgroup.

FRAUD AND ABUSE IN MANAGED CARE

Health care reform movements in Florida and at the national level are based on the managed competition strategy and includes greater reliance on managed care. At this time, the impact of fraud and abuse in managed care systems is unknown. In a prepaid, capitated payment system, the incentive to provide unnecessary services and manipulate billing should be reduced. However, the incentive for improper screening and excluding patients or services is enhanced, and detecting this type of fraud and abuse may be more difficult.

Quality of care problems may occur more frequently in managed care than in the traditional fee-for-service programs, such as the underutilization of necessary services. As we move toward greater reliance on managed care, fraud and abuse detection must be adapted to changing incentive systems.

INITIATIVES TO COUNTER FRAUD AND ABUSE

Anyone with knowledge of fraudulent activity can potentially file a suit under the federal False Claims Act. Having many potential "watch dogs" in the health care industry increases the chance of detecting and prosecuting fraudulent activity. Currently, Florida lacks a similar law. Florida's Attorney General has drafted legislation modeled after the federal False Claims Act that could, if enacted, significantly improve our ability to detect and prosecute fraudulent health care providers.

Civil and criminal actions that combine the detection, investigation and prosecution expertise of different agencies avoid duplicative efforts and increase the effectiveness of health care fraud prosecutions. In 1990, Governor Chiles met with former Attorney General William Barr to initiate health care fraud and abuse task forces in each of Florida's three federal districts. These efforts are now demonstrating preliminary results and should be expanded.

Florida laws require the reporting of suspected fraud, and immunity for doing so. Section 626.989(4)(c), Florida Statutes, includes provisions which remove any civil liability for libel, slander, or any other relevant tort for persons acting without malice and in the absence of fraud or bad faith. Similar statutes can be found in other states. Florida law also requires licensed health care providers to report fraud and abuse, although it does limit regulator access to the information.

The Agency for Health Care Administration has purposed legislation to further strengthen Medicaid program integrity statutes. Emphasis will be placed on avoiding payments of public funds to abusive or fraudulent providers and pursuing faster civil remedies and administrative sanctions. Measures are also proposed to make it more difficult for bad providers to enter the Medicaid program.

BARRIERS TO COMBATTING FRAUD AND ABUSE

Weaknesses in existing laws hinder efforts to control health care fraud and abuse. Providers can receive a billing number, steal thousands of dollars, declare bankruptcy, and reopen impunity. Even when the state suspects that a provider has committed fraud or abuse, current state law requires that costly reimbursements continue until there has been a finding of fraud or abuse.

Private health insurers are constrained by legal and administrative limitations from collaborating on efforts to confront fraudulent providers. Even when fraudulent providers are caught by one insurer, they can continue billing other insurance companies.

Despite the diverse sources of information found in data bases within state, federal and private organizations, there are many instances where agencies and private participants are prohibited from sharing that information, especially for ongoing investigations and litigation. Earlier detection through information sharing reduces health care expenditures to the perpetrator of fraud, and reduces the costs of investigations leading to prosecution. There are, however, various technical, risk management, legal and ownership barriers to sharing data which must be addressed.

There remains tremendous need to improve coordination among the various organizations that have responsibilities for identifying, investigating, and prosecuting health care fraud and abuse. While some intergovernmental coordination and information sharing among public and private organizations occurs, more could be done. At the federal level, the Justice Department, the Postal Service, the Drug Enforcement Agency, the Food and Drug Administration, and the Department of Health and Human Services all have related investigatory responsibilities. At the state level the participants include the Agency for Health Care Administration, the Department of Legal Affairs, the Department of Insurance, the Department of Elder Affairs, the Comptroller's Office, the Department of Business and Professional Regulations, the Office of the Auditor General, the Department of Labor and Employment Security, and the Department of Law Enforcement. Improved coordination and cooperation among the various players would enhance the ability to tackle the problem.

FRAUD AND ABUSE WORKGROUP RECOMMENDATIONS

Recommendations made by the fraud and abuse workgroup follow. I will touch on some of those.

1. Implement continuing medical education licensing requirements for doctors and other health professionals to include a component on medical ethics, billing and business practices and increase health professionals educational requirements for identifying health care fraud and abuse.

2. Expand consumer education on health care fraud and abuse.

3. Require all health care insurers and providers to establish fraud and abuse compliance programs for their employees to detect and prevent violations of the law.

4. Implement a public and private false claims act, with a quiam provision.

5. Continue the Health Care Fraud and Abuse Work Group to coordinate the activities of and communications with private and public sector parties involved in such actions, and facilitate the efficient, expeditious promotion of health care fraud and abuse investigations and prosecutions.

6. Increase criminal and civil penalties for those committing health care fraud and abuse, ensuring that health professional licensure accounts for a professional's criminal and civil penalties.

7. Implement a program integrity concept (similar to the Florida Medicaid Program's) in other programs involving state funds (e.g., Workers' Compensation and State Employees' Health Insurance) to provided oversight of public monies.

8. Define "health care fraud" and "health care abuse" to address the unique aspects of health care prosecution.

9. Establish a health care fraud and abuse trust fund in each agency that has health care fraud and abuse responsibilities.

10. Establish specific guidelines, standards and models to avoid abuse related improper diagnosis and treatment.

11. Expand immunity from civil tort liability for information sharing among providers and insurers.

12. Study the feasibility of eliminating restrictions to investigators' access to various state and national data bases that contain relevant fraud and abuse data.

In closing, I would like to say there is a great deal yet to be done in the area of health care reform at the state and national level. In modeling these programs, strong federal laws and rules aimed at minimizing fraud and abuse activities would assist states in meeting this goal.

Thank you Mr. Chairman and Members. I will be happy to respond to any questions.

RDN/ February 22, 1994

Mr. TOWNS. Thank you very much, Mr. Noble.
Mr. Whiddon.

STATEMENT OF JOHN M. WHIDDON, PROGRAM ADMINISTRATOR, FLORIDA AGENCY FOR HEALTH CARE ADMINISTRATION

Mr. WHIDDON. Thank you, Mr. Chairman. It is indeed a pleasure to appear before you today.

The material that I have presented in written form will certainly be far more extensive than what I am going to discuss with you now. I have some themes that are in some ways going to supplement what Mr. Noble has been discussing, and I am going to be speaking rather than reading. So hopefully it is going to be intuitively obvious to the casual observer that we did not compare notes before we got up here.

One of the first things that I would like to discuss is that this percentage of 10 percent has been tossed around a great deal and it has kind of taken on a life of its own. I am not sure that anybody has any idea what the real percentage of fraud and abuse is, but I think there is a consensus that whatever it is, it is significant.

I think in Florida alone, if you look at a budget of $7 billion and you look at the amount of recoveries from $7 million to $12 million a year, that there is a great deal of fraud and abuse we have discovered, but there is also a great deal of fraud and abuse that remains to be discovered and dealt with.

The issues associated with this type of theme have to do with the fact that let us not forget, there are problems other than fraud that have to be dealt with. You have to deal with quality of care issues and you also have to deal with abuse. Abuse can be anything to the system from a simple mistake to what we refer to in the business as premeditated carelessness. There are a lot of things that are absolutely fraud that you will never be able to prove as fraud. And in that respect, you can suspect that a criminal approach is not going to be very effective in dealing with those kinds of issues.

The first theme that I want to address to the committee is the fact that—and it is almost Biblical—in the beginning—the provider enrollment process in Medicaid is nothing more at this point in most of the States that I have observed than a glorified clerical process. We have got to do something to put integrity and accountability into that enrollment process in order to have some success. As the GAO representative indicated, we have a lot of people that end up coming back into the system disguised or camouflaged after they have already been dealt with. We have got to be able to build that kind of integrity in, whether it is through some type of bonding mechanism or some type of overall program integrity responsibility on the part of the agency.

The second theme that I would like to briefly mention to the committee is that detection is not the problem. We have great detection capabilities, either analytical, statistical, a lot of modeling assimilation designs that far exceed what Federal requirements indicate under the surveillance utilization and review guidelines. It is very easy to detect cases, the real problem has to do with the investigative capabilities to follow up these kinds of detection strategies.

In the pharmacy area alone, if we sent everything over to the Medicaid Fraud Control Unit that we had a suspicion was fraudulent, they would not have any time over there except to just open mail. So the detection capabilities far exceed the investigative capabilities.

The third theme has to do with the training and experience and the resources for conducting investigations in the health care area. Right now, we hear that a lot of the HHS OIG folks have been taken out, rearranged, shifted, and at the same time there have been other entities, the FBI, getting more involved in the health care fraud area. It is an excellent opportunity to have additional resources, but I think it is a little naive or short-sighted on our part to think that there is going to be great help real quick from these types of resources if you do not put the right kind of training behind these people. It is one thing to do an accounting type audit and fraud audit in the general savings and loan issues or to bring people from foreign service, but to expect them to be efficient in health care fraud areas, which is a totally different type of animal, is not going to be very effective. Medicaid alone is extremely complex, the systems are complex, the eligibility rules are complex, the coding systems are complex, the ICD9, ISDs, HCPCS, all of these things are totally new concepts to individuals that do not have any training in the health care area. Whereas you would not expect a nurse to be very effective in the savings and loan area, I do not know that you could expect an accountant to be very effective in dealing with health care issues without a significant amount of retraining.

The next theme is that the criminal approach has not been very effective historically in the State of Florida. And as I pointed out earlier, I do not know that you could expect them to be very effective if they are not dealing with criminal matters. Abuse is far more prevalent than fraud.

In Florida, I think over the last decade there has been a total of about 90 days in jail time for individuals that were prosecuted through the State attorney's offices.

The fifth theme which I will just very briefly mention is that solicitation may be the hammer that drives the nail. Some type of kickback scam seems to influence the largest types of crime that we have.

And finally, managed care may not be the savior that we all think it is. It may bring on some totally new types of fraudulent activity that we have not even considered. We can recall the infamous IMC case here in Florida, and also the managed care fiasco in the State of Arizona, to just point out a couple of these areas.

There are some things that could be done immediately at the Federal level that would help the States, and I will be happy to respond to them. They are in my written material but I will also be happy to respond if there are questions.

Thank you so much.

[The prepared statement of Mr. Whiddon follows:]

TESTIMONY
JOHN M. WHIDDON, PROGRAM ADMINISTRATOR
FLORIDA AGENCY FOR HEALTH CARE ADMINISTRATION
MEDICAID PROGRAM INTEGRITY

FOR

CONGRESS OF THE UNITED STATES
HOUSE OF REPRESENTATIVES
SUBCOMMITTEE ON HUMAN RESOURCES
EDOLPHUS TOWNES, CHAIRMAN

FEBRUARY 25, 1994
MIAMI CITY COMMISSION CHAMBER
3500 PAN AMERICAN DRIVE
MIAMI, FLORIDA

Florida Medicaid Program Integrity

John M. Whiddon, Program Administrator

Agency for Health Care Administration

From November, 1985 through July, 1993, I had the opportunity to serve the state of Florida as Chief of Medicaid Program Integrity. During that time, I was fortunate to become very acquainted with counterparts in other states and was extremely privileged to be active in the National Association of Surveillance Utilization and Review Officials (NASO). It is from these experiences that my perspectives have been formulated.

I do not intend to debate the percentage of health care fraud and abuse either nationally or in Florida. I will leave that to the health care economists and actuarial scientists. While I do have some thoughts on the matter and have included some comments in this presentation, I think it should suffice to say that there is consensus that the problem of health care fraud and abuse is significant.

The dawning of Health Care Reform makes it almost imperative in the area of health care fraud and abuse to pause and take stock of where we came from, reflect on what has worked and what has not and suggest some future paths and strategies for consideration. Even without Health Care Reform, the Medicaid Program Integrity concept was poised for a new era. While it has been suggested that the Medicaid Program may well become invisible under Health Care reform, let us hope that the Program Integrity concept does not become invisible and thus vanish. Whatever form health care service delivery takes, accountability must be implicit and the question asked, "Did we get what we paid for?"

The material presented herein is not intended to be scholarly nor is it completely objective. Experience, success, failure, observation, experimentation, insight, bias and opinion form the basis for what can best be described as an editorialized status report on the Medicaid program integrity concept. While some peers will certainly question the wisdom of producing such a document, I can only respond by suggesting that after almost thirty years of public service and in the twilight of such a career, not to share such a synthesis should almost be considered an act of misfeasance.

The organization of this material may appear to be haphazardly disjointed. I prefer to refer to it as a premeditated thematic approach, sprinkled with historical references, that incorporates neither a comprehensive review, an exhaustive review nor a mutually exclusive view of oversight issues in the Florida Medicaid program. A section on problems and potential solutions has also been included for provoking thought on such issues. Some of the problem issues are limited to the Florida Medicaid Program. Others may represent implications for much broader applications.

A major purpose of this document is to share experiences and insights that may serve as a springboard for those individuals involved in the Health Care Reform who will be revamping the strategies to combat health care fraud and abuse. In addition, there is a certain amount of hopeful anticipation that an administrative catharsis may occur which will share and promote the vision that the Medicaid program integrity concept is applicable and is easily adaptable to other health care areas.

Medicaid
Fraud and Abuse in Florida
Issues and Insights

Funding may already exist for Health Care Reform. All that is necessary to bring this about is to have even limited success in the War Against Health Care Fraud and Abuse.

The past decade has witnessed undreamed of growth in terms of Medicaid eligibility and expenditures at both the federal and state levels. Costs increased at an average compound rate of 14.5% per year between 1973 and 1980. The number of Medicaid recipients has grown due to population growth, changing demographic characteristics and the economic recession. In 1970, total Medicaid expenditures totalled $5 billion. In 1991, that figure was $84 billion. It is projected that by 1995, that the figure will reach $150 billion. It is anticipated that the amount of health care fraud and abuse will grow proportionately. In order to curb health care fraud and abuse, there is going to have to be a new appreciation for the complexity of Medicaid as well as some risk taking with respect to new approaches.

Medicaid is complex. The organization and administration is complex, the policy is complex, the eligibility is complex, the systems to run it are complex, the pluralistic interfaces are complex and the size and massive growth make it complex.

Medicaid is simply a complicated program. The Medicaid program has been described by the United States Supreme Court as follows: "The Social Security Act is the most intricate ever drafted by Congress. It's Byzantine construction, as Judge Friendly has observed, makes the Act almost unintelligible to the uninitiated." Schweiker v Gray Panthers, 101 S. Ct 2633. Less complimentary descriptions include "Take any major insurance program, throw in the federal government and let each state administer it and then try to describe what it is. One such description is an architectural monstrosity, envisioned by those of questionable intellect, created by a process of disjointed incrementalism, refurbished routinely with random mazes and administered by a least 50 plus or so rugged individualist prima donnas."

The complexity of Medicaid and health care fraud and abuse issues cannot be underestimated. Before it is possible to deal

with the abusive aspects of the Florida Medicaid program there must be an appreciation for the complexity of this state/federal funded program in addition to the uniqueness of administrative, civil or criminal legal applications available and appropriate for aberrant practices. There is generally not such comprehension even in some of the most sophisticated public policy planners, regulatory authorities or those with judiciary responsibilities.

While, for the purpose of this endeavor, there is no intention to go into any elaborate orientation of the Florida Medicaid program, there is for illustrative reasons a need to share a few of the complex insights. In order to understand even the most generic overview of the Florida Medicaid program it is absolutely imperative that one know something about eligibility groups, service coverages, participating providers, legal basis and systems.

The Florida Medicaid Program serves approximately 1.6 million recipients, predominantly in two major programs: Aid to Families with Dependent Children (AFDC) and Supplemental Security Income (SSI). A third group of recipients are refugees, eligible under a special federal program. The recipients receive medical services through a combination of fee-for-service and pre-paid arrangements with Medicaid providers and managed care programs.

The Florida Medicaid program currently recognizes over 50 valid provider types who render a full spectrum of medical services to recipients, ranging from physician and hospital services, to dental care and private transportation. **The program has over 55,000 participating providers** and has implemented three managed care programs. **Providers submit approximately 80 million claims** for reimbursement per year. These claims are adjudicated through a contracted fiscal agent that has overall responsibility for operating and maintaining a certified Florida Medicaid Management Information System (MMIS). The Management Information System has twelve major subsystems which combine automated and manual functions for not only adjudicating claims but for providing historical references, maintaining report requirements, and effecting system interfaces with other external systems operations. Reportedly there are **over 250 miles of hard coded programming** in the FMMIS. On any given claim there is the possibility of the claim being **subjected to 745 edits** that may either pend or deny such a claim.

The FMMIS is a massive system. While a health care fraud and abuse investigator is certainly not expected to be an expert, there must be an understanding of what the system can and cannot do. It is also imperative to know what information is readily available from the system and how the various subsystems interface, interact and sequence themselves before one can even begin to tackle a fraud and abuse problem. There are numerous examples of situations thought to be gross program abuses only to discover that the abuses were system generated.

The eligibility for Medicaid services itself can be a nightmare for even the most veteran eligibility workers. Historically, groups of Medicaid eligibles have fallen into two groups, either public assistance or SSI. More recently, however, due to exceptions granted to special groups and waivers, there are any number of not necessarily mutually exclusive categories of Medicaid eligibles. This kind of description and analysis of each of the various subsystems could go on in great depth for a considerable amount of time. It should suffice to say that traditional knowledge bases related to audit type investigations, either criminal or civil, are not adequate and will not work for health care fraud and abuse investigations.

Approximately eight years ago, the Medicaid Program Integrity Office in Florida initiated a self-study and as a result of the analysis, developed a Total Quality Management (TQM) concept. TQM installation had an immediate impact and set the stage for the thinking and philosophy that prevails currently within the organization.

There were several significant insights that emerged almost from the beginning of the TQM process. The first major insight related to the fact that given the history of resource allocations it was going to be necessary to work smarter if post payment review actions were to keep pace. Along this line of thinking, an on-going assumption was established as a given and that was the continuous assessment of where was the biggest return for the investment. A consensus was established with regard to quantitative strategies that would combine the analyses and investigations of multiple providers and emphasize such approaches. Still another feature of TQM was that it was always going to be necessary to build new and better mousetraps.

The most important realization that became immediately apparent from the TQM process was that health care regulatory analyses, audits and investigations were very unique and not comparable with investigations conducted by other professional investigators in other disciplines. Acknowledging this reality formed the basis for an assembly line specialization along with an adhocratic task force, team approach composed of traditional investigative professionals, various health care professionals, systems experts and legal support staff.

Frankly, it is just not reasonable to expect traditionally trained law enforcement types to be particularly efficient or effective in the health care area. Just as it is necessary to look towards specially trained attorneys, accountants and management specialists to investigate white collar crime, it is even more imperative that individuals involved in health care fraud and abuse investigations not only come from these ranks, but also from the professional health care ranks and systems areas as well. To conduct appropriate health care cases it becomes obvious as to why it has been necessary to take a task force approach. It would be a rare and exceptional individual indeed that would possess the

business, technical, professional, investigative and systems expertise necessary to effectively deal with all the various kinds of health care fraud and abuse scams. From just the professional area alone, the knowledge base necessary to attack aberrant health care schemes requires specialization in medical nomenclature, HCPCS Coding Systems, ICD9-CM Diagnostic coding systems, relative value systems, procedure/diagnostic compatibility, drug interaction profiles, medical record organization and format, facility utilization review procedures, quality assurance matrices, professional protocols, standards for care and licensure and certification requirements. Couple this knowledge base prerequisite with the health care insurance policy coverages limitations and exclusions for just one of the 50 or so service areas and one should be just slightly overwhelmed.

Finally, another complicating factor integrated into the total process are the various agencies and jurisdictional questions relating to health care fraud and abuse. According to some, there may be more people looking for fraud and abuse then there are people committing it. A partial list of organizations that investigate or prosecute Medicare and Medicaid fraud and abuse includes:

Office of Program Validation of the Bureau of Quality Control of the Health Care Financing Administration,
Office of Inspector General of the Department of Health and Human Services,
. Federal Bureau of Investigation,
United States Attorney's Office,
United States Treasury Department,
United States Attorney General's Office,
State Medicaid Fraud Control Units,
United States Postal Service,
General Accounting Office,
United States Secret Service,
State Medicaid Program Integrity Units,
State Attorney General's Office, and
State Department of Professional Regulation and Financing Agencies.

Again, the emphasis here is to point out that Medicaid and health care fraud and abuse is different and complicated. No one is going to come in overnight and make a major impact without going through a learning process. Furthermore, it has got to be like a cat eating a grindrock, it is going to have to be taken real slow and a little bit at the time.

Along with all this Medicaid growth and complexity has occurred a growing concern over the need to control fraud and abuse. Over the past several years a great deal of information has been put together on the topic of health care fraud. For a general orientation to fraud control it is important to note that fraudulent treatment and billing practices can take on a number of different forms: the provision of services that the provider knows

to be medically unnecessary, billing for services not actually provided, knowingly furnishing inferior services or products, coercively soliciting contributions, and knowingly billing recipients or responsible parties for services paid in full by Medicaid. Medically unnecessary services are quite prevalent, but it is difficult to establish motivation other than "treatment in the best interest of the patient." Billing for services not rendered is somewhat less difficult to prove, as the investigator need only determine whether services billed were actually rendered.

Actions that can be taken against provider fraud and abuse in Florida range from provider education by Medicaid field staff to criminal prosecution by a state attorney. Provisions exist, for example, for the suspension or termination of a provider's participation in the Medicaid program. The ability of state agencies to investigate and prosecute fraud has been increased by the passing of various legislation, including Public Law 95-142. Under this federal legislation, most fraudulent acts previously classified as misdemeanors are now felonies. Titles XVIII and XIX of the Social Security Act provide for pre-delivery, concurrent, and post-payment review of Medicaid-reimbursed services by such entities as peer review organizations and surveillance and utilization review units. The Florida Statutes contain several specific provisions for controlling Medicaid fraud and abuse. Section 11.50, Florida Statutes (F.S.), gives the Auditor General the authority and responsibility to investigate irregularities related to public assistance. Section 409.325, F.S., defines crimes and punishments for recipients, providers, and administrators of federally funded assistance programs. Section 409.913, F.S., provides for oversight of the integrity of the Medicaid program through the establishment of an office "to oversee the activities of Medicaid recipients, and providers and their representatives to ensure that fraudulent and abusive behavior and neglect of recipients occur to the minimum extent possible." Provisions include the referral of any suspected criminal violation or fraud to the Medicaid Fraud Control Unit of the Office of the Auditor General. Section 409.355, F.S., makes it the responsibility of HRS to recover funds paid to public assistance recipients or providers by error or fraud.

Efforts to control fraud have been hampered by a number of factors, including incentives within the system for providers to cheat, budgetary constraints, evidentiary problems, and a court system that is already overwhelmed by cases involving street crime. According to Gardiner and Lyman, one of the most important strategies in fraud control is the development of alternative sanctions. Ordering providers to repay excess receipts, they state, has little deterrent value, while criminal prosecution is a realistic possibility in only a small number of cases. Between these two extremes lies the possibility of sanctions that can be invoked rapidly, less expensively than with criminal prosecution, and without the need to prove criminal intent. Gardiner and Lyman suggest the approach of adding interest charges and penalties, invoking civil fraud statutes, or imposing administrative sanctions

as effective strategies that have been adopted by some state agencies, including Florida. The authors also suggest more generic approaches to encouraging the utilization of fraud control techniques, including combating the inertia produced by decision costs and/or the costs of other opportunities that must be forgone in favor of expenditures for fraud control.

According to Gardiner and Lyman, prevention, as well as enforcement, can be emphasized if agencies are given the incentives to emphasize fraud control. The Comptroller General, in a report to Congress, emphasizes the importance of the deterrence aspect of fraud control. In the absence of effective investigative units, the report states, individuals engaging in fraudulent practices would be able to continue their activities virtually unchecked.

Contrary to what has been reported by the media, quick help is not on the horizon. Recently, there has been publicity regarding the transfer of FBI agents into the health care fraud arena. There is also a mandate to the U.S. Attorneys throughout the states to get aggressive in health care fraud prosecutions. It is exciting to see the possibility of some of the tools and strategies used by DEA and the Justice Department applied to fraudulent health care providers.

While these efforts are to be applauded, and may eventually yield some results, it is overly optimistic to suggest any sudden impact as a result of these resources on the scene. This fact comes from the amount of retraining that will be required in language, systems, organizational orientation as well as a change in traditional investigative modus operandi. Many of the FBI agents are entering the system fresh from the savings and loan areas or from the foreign service duties. As per their orientation many of these agents and Justice Department officials are appearing on the scene with a criminal investigative and prosecutorial mentality. Experienced health care fraud examiners and regulatory specialists in the health care areas will emphasize that this orientation is generally inadequate and will probably be less than effective in the health care arena. There are two very recent examples that illustrate this point almost perfectly.

The first example relates to a highly skilled, motivated and professional prosecutorial entity, but one that was also inexperienced in health care issues. In this situation, the prosecutors did not appreciate nor consider the specialization and appropriate discretionary subjectivity of the peer review process and were suggesting the application of treble damages against legitimate well-intentioned providers that had every right to professionally disagree with desk audit decisions regarding their care of patients. There were no false claims as prosecutors assumed, nor were there determinations of overpayments that had not been reconciled.

The second example is an embarrassing illustration and points out that it is not only novices to health care investigations that make egregious errors. Recently, a highly trained, dedicated and

conscientious Health Care Fraud investigator without, however, consultative backup, concluded a criminal investigation against a pharmacy provider. Criminal information was filed and the pharmacist was arrested, all the while protesting his innocence. During a normal discovery deposition, it was revealed that the investigator's lack of sophisticated ability to differentiate between liquid and tablet NDC codes led to erroneous conclusions that formed the basis of the criminal case. The pharmacist was guilty of nothing whatsoever. The investigator and agency involved were extremely embarrassed to say the least.

The criminal approach to health care fraud has generally not worked and there are some pretty apparent reasons why not. First of all, with certain notable exceptions like the Daniel Wineberg Federal Court case in New York, there have been few major successes in comparison to the reported incidences of health care fraud and abuse. Over the past decade for Medicaid fraud cases that have been prosecuted via State Attorney offices, there has been a total of 90 days jail time in two separate convictions.

For reasons maintained earlier, health care fraud cases are difficult to detect as such, investigate and prosecute. For instance, a provider that upcodes a procedure code every now and then may never be detected in an insurance review. Even if he were detected, the likelihood of being able to prove it as a deliberate and fraudulent act would be remote. As for the investigation of a health care fraudulent act, anything beyond an absolute payment for a service that was not delivered gets to be just slightly harder than pulling hens' teeth to prove. Evidence requirements, reasonable doubt requirements, amount of violations needed to meet criminal felony criteria, lack of witness cooperation or knowledge and the length of time to conduct undercover operations are just several of the reasons that the investigative process is extremely hampered and contributes to the ineffectual criminal approach. Assuming that an appropriate detection has been made, a proper investigation has been conducted and evidence supports a criminal charge, there continues to be a very good probability that the case will not be tried. A large majority of cases in this classification are either not prosecuted and returned to the initiating state agency for administrative remedies, or are settled with a pre-trial intervention stipulation.

The startling reality of the situation is that the administrative remedies are far more harsh, easier to administer, more effective and certainly more timely than criminal remedies.

Although there is certainly room for some improvement (which will be dealt with later), the Florida Medicaid program is blessed with maybe the strongest state Medicaid oversight statute in the country. Chapter 409.913 F.S., gives investigative and regulatory responsibilities a broad and aggressive base and provides significant sanctioning ability for providers involved in aberrant practices. The determination of overpayments coupled with the application of sanctions has proved to be a much more efficient and

effective mechanism for dealing with aberrant practices, ridding the program quickly of unscrupulous or undesirable providers. As for recipient fraud, there has never been a great deal of emphasis due to the fact recipients are not paid directly for medical services and to obvious consequences of taking on such a task. If a recipient has ever been prosecuted and convicted of Medicaid fraud in the state of Florida it is unknown. What would be achieved, even if successful? Would the recipient go to jail? Would the benefits be withdrawn? Would money be repaid? Not likely.

Florida Medicaid oversight has taken the position that in light of resources available, the emphasis should focus on abusive providers. It is simpler, more cost effective and realistic to pursue abusive providers that may be treating a hundred different recipients, than it is to pursue each of the hundred different recipients. Given the resources available, this has been a deliberate strategy that has yielded excellent dividends.

To what extent is fraud and abuse evident? The enormity of the problem is not really known. How much fraud and abuse is there anyway? **Honestly, nobody really knows how big the problem is.** Just as organized crime does not report what it steals neither do those involved in health care fraud. There are any number of health care economists and actuarial scientists that have suggested a percentage of 10-22 percent of the entire health care budget as being inappropriate. Not one reliable piece of empirical evidence from a reputable quantitative study can be located to support or in any way substantiate this percentage. Interestingly, the percentage has been used so often without question that it is stated as a given and has taken on new life of its own. **The probability that 10-22 percent of all expenditures are "fraudulent" is deemed preposterous and absurd by most experienced health care fraud examiners and regulatory health care professionals.** The most probable explanation of the 10-22 percent, complete with disclaimers, is that 10-22 percent of <u>non-institutional</u> health related expenditures are either fraudulent, abusive or unintentional mistakes that encompass false billings and misutilization of services. Some of these abuses are deliberate, some are unintended, some are often referred to as premeditated carelessness.

It is possible to measure only by inference that which cannot be or has not been detected. When quantitative methods are not practical, qualitative methods such as observation, participant observation or surveys must be utilized for deducing such inferences. With this thought in mind, information is available from the experiences of many persons at the federal and state levels. From such individuals with Medicaid auditing and investigative experience have arisen numerous estimates of the extent of fraud and abuse in the Medicaid program across the country. Most of the estimates from these sources place losses due to Medicaid fraud and abuse from 5-15 percent of program expenditures. The most common fraction given is 10 percent. In a

meeting of the National Health Care Anti-Fraud Association in Miami, Florida in November 1989, a senior official of the New York Medicaid fraud control unit held emphatically that Medicaid fraud in that state represented no less than 10 percent of program expenditures, which at the time, exceeded 10 billion dollars annually.

Florida is certainly not immune to health care fraud. Again, while it is not possible to be aware precisely of the extent of fraud and abuse in Florida Medicaid, it is known from experience with more than 12,000 audits and investigations over the past ten years or so that it is significant. Some argue that it is probably relatively lower in Florida than in most other large states because of the number of prepayment screens or edits in the claims processing system. In addition, others suggest that it is due to the numerous limits or caps on services, the extensive provider education programs that have been carried out by the fiscal agent contractor and the Medicaid provider relations office, and the deterrent efforts of thousands of interactions that auditors have had with providers over the years. Although there are some disciples of the 2-4% school of thought, there are certainly those representing the other extreme. At least one high-ranking federal official from HHS/OIG, addressing the 1990 conference of NASO in Detroit, referring to the amount and variety of fraud and abuse scams, remarked, "If it hasn't happened in New York, California or Florida,(especially Florida), it hasn't been done or thought of yet."

The amount of fraud and abuse in the Florida Medicaid program is really irrelevant. It's like stomping ants in the basement while elephants run wild on the first floor. Assuming that the absolute best estimate of fraud and abuse in the Florida Medicaid program is from two to four percent of services expenditures overall, it should become intuitively obvious to the casual observer that there is much more that can be done than has been done. With even the most conservative estimates based on current Medicaid expenditures, losses are more than likely in the neighborhood of $200,000,000. Since the program integrity office is currently recovering time period overpayments at the rate of $7,000,000, including recoveries through contractors performing utilization reviews, it is apparent that there are great opportunities to increase recoveries.

From a qualitative evaluation perspective, the following examples illustrate generically the literally scores of examples of fraud and abuse in the Florida Medicaid program. In amounts, these examples vary from small sums to thousands of dollars, and in some cases, to hundreds of thousands of dollars.

Medicaid program integrity found that a pharmacy provider billed Medicaid for $50,000 worth of drugs that it had not purchased, and that was for only ten drugs for a four-month period. A certified public accounting firm recently audited five pharmacies respecting a number of drugs to determine whether the pharmacies

had purchased drugs in quantities as great as the amounts billed to Medicaid. Assuming all drugs purchased were available for Medicaid recipients alone, the shortfall was $118,684 or $23,700 per pharmacy for a one-year period. Audits of this type (aggregate analyses) reveal only the most flagrant violations and only a portion of actual total overpayments.

The pharmacies that were audited are by no means unique. Similar results have been found with regard to many other pharmacies. The rate of overpayments to pharmacies in Florida Medicaid could well be ten percent, which would amount to $30 million a year in that one service area alone.

Certain health units were paid by Medicaid a total of $14.1 million over the audit periods involved. Based on actual overpayments found, the point estimate of the total overpayments to those units is $2.7 million, close to a 20 percent overpayment rate. Looking at payments to physicians for hospital visits through a chi-square statistical analysis, the total overpayment calculated was $1.04 million out of total payments of $18.06 million, an error rate of nearly six percent. A similar analysis underway relating to physician office visits has revealed preliminary results of overpayments amounting to about five percent of the total payments. Experience in auditing Medicaid payments to physicians would suggest an error proportion of possibly ten percent, placing total annual overpayments at more than $30 million in that service area.

Substantial overpayments to some dentists have been found. In Florida, the Medicaid program does not provide adult dental services except for dentures and related procedures. Dentists have been found to bill Medicaid for procedures presumably in anticipation of or related to the furnishing of dentures without ultimately actually furnishing them. Many times such work and billing are done in good faith, sometimes not. Excessive billings of behavior management, pulp cap, periodontal scaling and other procedures have been noted.

Investigations of several home health providers resulted in the identification recently of overpayments totaling $2.6 million to four providers. Some time ago when several other home health providers were reviewed, overpayments of hundreds of thousands of dollars were found. While total payments to home health providers represent a very small fraction of all Florida Medicaid payments, excessive payments to providers in this service area are significant.

Laboratories represent a program integrity concern. In another state, a small group of laboratories with common ownership defrauded that state of more than $50 million in less than a year. A Florida businessman involved with several laboratories embarked on a similar scheme. Overpayments to those laboratories have exceeded $4 million. It is estimated that the exclusion of these providers from further participation in the Medicaid program will

have achieved $15.6 million in abuse avoidance during the first year following exclusion.

In one area of Florida, a network of more than a dozen providers thought to be engaging in collusive practices has been discovered. Preliminary investigations have revealed that they may be engaged in bribery, kickbacks, improper cross-referrals, client solicitation and other acts to defraud or abuse the Medicaid program. Overpayments to these providers have thus far been determined to be $3.8 million, with that amount increasing rapidly as the investigation progresses. The scope of the ongoing and prospective investigation is extensive, limited only by the small number of available investigators.

Overbilling in transportation has been determined resulting from billing for trips not furnished, and padding mileages and numbers of passengers. Some prior authorization responsibilities have been contracted and difficulties have been found with some of the firms that have been awarded contracts. Overpayments in transportation services represent a serious concern to program integrity auditors and managers.

Crossover claims to Medicaid from Medicare (the federally-administered insurance program) lead to substantial overpayments, in part because of the nature of policies and procedures relating to them, and in part because of clever billing practices by many providers. Particular problems have been found respecting durable medical equipment (DME) and occupational and speech therapy billings. In some instances, two DME providers bill for the same item, for the same recipient, or one provider bills an item using two different numbers, or providers bill a lease item with different provider numbers in different months to interrupt tracking the lease period, which is limited to a certain number of months. Problems with crossover therapy claims arise in part due to lack of controls by Medicare, which supposedly pays the community going rate. Then Medicaid pays the 20 percent co-insurance amount. Medicare has paid $273 for a fifteen minute unit of speech therapy, whereas the going rate is $23 per 15 minutes in the geographical area involved. The precise proportion of fraud and abuse related to crossovers, and that respecting DME and therapy billed directly, are not known, however, enough misbilling has been discovered to suggest that these areas deserve more detailed scrutiny in addition to a tightening of policy.

No amount of experience or analysis can serve to determine exactly the extent of fraud and abuse in the Florida Medicaid program. Opinions, no matter how much experience may go into formulating them, may be dismissed as speculation. But it is a fact that as the number of investigators has been increased, recoveries have increased generally proportionately. The point of diminishing returns in recoveries arising from audits has not been approached, and that is the most important consideration. In all likelihood, if auditing efforts are increased by a factor of three or four, recoveries would also rise by a similar factor.

What occurred to get us into this situation? Before proceeding with solutions to resolve some of the problems, it is probably worthwhile to determine how the current situation developed.

For the most part, there are two primary historical reasons that health care fraud and abuse has evolved to its present overwhelming status. First of all, private industry insurance models, including those outside health care third party payers, have routinely viewed the expenditures associated with fraud and abuse in much the same way a retail businessman treats shrinkage. It is simply a cost of doing business and, therefore, it is passed on to the customer through inventory markup. This mind-set is currently undergoing a major metamorphosis due mainly to a number of joint public/private partnerships and the demonstrations, primarily from the public arena, that it is possible and desirable to rid the industry of such providers since these providers cost even more money in the long run. Although it might not be exactly historically accurate, the Medicaid program, via its surveillance, utilization and review requirements, program integrity mandates, and establishment of Medicaid fraud control units actually pioneered the way for the private sector and demonstrated that fraud and abuse costs should not be considered as just costs of doing business.

Another contributing factor to the present state of affairs was the initial philosophy established by health care policy decision makers during the dawning phases of federally funded health insurance programs. For administering Medicaid programs, most state agencies initially adopted a provider orientation, emphasizing the payment of providers at rates approaching private patient costs, a simple enrollment process, simple claim forms and screening of these claims, rapid reimbursement, and minimal post-payment audit and investigation. This approach was adopted because it reflected the intent of Congressional legislation, because it was believed necessary in order to induce providers to participate, because providers were politically powerful in many states, and because most state agencies lacked the technical capacity to develop monitoring systems.

Until the late 1970s, most state Medicaid agencies felt little incentive to control provider costs. When fiscal stress became apparent, many states found themselves without a mechanism to identify fraudulent or abusive claims. To deal with these problems, states began to adopt a control orientation toward providers, including comprehensive provider enrollment and claim forms, greater utilization of prepayment analysis, and systematic utilization control, and investigation of patterns of aberrant practices. One of the mechanisms employed for this purpose is the Medicaid Management Information System (MMIS), which is designed to provide information necessary to effectively control the health care delivery system funded by the Medicaid program.

In the Florida Medicaid Program, a number of utilization controls exist at the prepayment, post-payment, and concurrent levels. Prepayment utilization controls include computer edits in the claims processing system and prior authorization by HRS/AHCA for the payment of services. Recipient cost sharing was once utilized in the Florida Medicaid program. It was, however, not shown to be an effective utilization control mechanism. (It is now in place as a budget-cutting mechanism.) Concurrent utilization control is exercised primarily in the areas of long-term and institutional care. Utilization control is accomplished at the institutional level through certification and recertification of the need for care by the attending physician, the physician's plan of care, utilization review, and medical evaluation and on-site review of care. Post-payment utilization control of all types of services is accomplished through the detection of inappropriate utilization of Medicaid services by recipients, the detection of inappropriate provision of Medicaid services by providers, the analysis of program policy and its impact on service delivery, and the exercise of fiscal control over federal and state tax dollars. Providers continue to not like these controls and the politicians appear to side with them.

The final reason that more has not been done is often referred to as the "Ostrich Syndrome." Quite simply, it has not been politically advantageous to break the proverbial cycle. Year-after-year, funding requests that attempted to deal with even the tip of the iceberg have seldom reached the Governor's recommended budget. Political appointees in senior management positions were not willing to be associated with admissions that such levels of fraud and abuse existed and were so out of hand, and appeared to yield to pressure from providers/provider groups, politicians, etc., to not recognize/acknowledge and correct the fraud and abuse.

Interestingly, this bureaucratic paranoia began to change almost overnight with a number of sequential back-to-back media extravaganzas. Among them was the T.V. Unsolved Mysteries, Daniel Wineberg case from New York, a major Sixty Minutes expose' on Medicaid fraud, a major feature article in U.S. News & World Reports and the media coverage of the Dr. Gerber case.

Almost overnight Medicaid fraud and abuse achieved attention from every conceivable direction, while in the past, Medicaid program integrity was expected to do its job and maintain a low profile. It was now directed to come out of the closet and share with the world what the problems were, what had been done about them and what was needed. Riding the crest of this new enthusiasm, Medicaid was able to set forth a number of legislative initiatives and requests for resources that were endorsed and ultimately provided.

Detection of aberrant providers is not the problem. Contrary to a number of popular opinions, there is no shortage of very good detection strategies to ferret out potential fraud and abuse cases. Without giving away such strategies, there are both traditional and

non-traditional methods for targeting, with a high degree of confidence, those identified individuals that are involved in questionable practices. During the last few years, the Medicaid program integrity office has developed a number of high-tech analytical, statistical and heuristic models that are used routinely for such identification. Many of these models have replaced the Surveillance and Utilization Review subsystem (SURS) as the primary source of referrals. In addition to cases that are generated in-house, there is always an adequate number of allegations reported through a variety of sources including recipients, their relatives, other providers, former employees, other departmental staff and other investigative agencies. The number of good cases to work far outdistances the investigative capabilities to deal with them. In one sense, this is probably the reason that Florida has been somewhat more successful than other states in determining and recovering overpayments and applying administrative sanctions. Early realization that a qualitative approach to policy compliance violations was not practical nor cost effective necessitated the development of quantitative generalized analyses that led to large recoveries from multiple provider groupings.

It is not possible to be certain at the time of claims payment, despite systems edits, that the services were fully and satisfactorily rendered in the manner claimed. That must await postpayment review. With Medicaid receiving 80 million claims a year in Florida, it is clearly not feasible to check each claim individually by manual techniques. Even if it were possible to do so, that would not be productive. It is necessary to analyze large volumes of claims by computer and make determinations about a provider's claims that cannot be made in prepayment review or draw inferences about them statistically.

The consequence to an enhanced detection capability is that it forces the system to treat many potentially fraudulent cases administratively. For example, in the Medicaid prescribed drug area alone, if all such allegations of drug diversion were referred to the Medicaid Fraud Control Unit's (MFCU) office, there would only be enough time to open mail. These kinds of fraud cases would simply overwhelm their investigative capabilities.

It appears that solicitation may be the hammer that drives the nail. In almost every single major Medicaid investigation over the past few years, the common denominator seems to be some form of solicitation that offers something of value to either a Medicaid recipient or a provider to utilize a particular service. Recipients may be unknowing participants in such an arrangement; others actually may create a business out of such knowledge. Providers almost by definition are knowledgeable participants in such endeavors. Regardless of the type of solicitation scheme and whether it results in the creation of a Medicaid mill or something on a smaller scale, the ultimate consequences are the same. In each case a medically unnecessary service has been provided that normally translates into false claims for Medicaid reimbursement.

Unfortunately, the problem has rarely been attacked head-on or from a criminal perspective in Florida. For the most part, the criminal approach has centered on proving grand theft. **Solicitation schemes have to be pursued from a RICO approach.** These are often complicated cases, take considerable time and are somewhat difficult to prove. It is understandable that MFCU's are not real excited about becoming involved in these kinds of cases since the primary yardstick used to measure their units' effectiveness is the number of convictions.

A regulatory agency can only be effective if it is shielded from political pressure and intervention. As a regulatory agency, program integrity very often finds itself involved in less than amicable relationships with various Medicaid providers. This is to be expected. Nevertheless, there are always providers that believe that the legitimate process can be circumvented or manipulated by attempting to engage the influence of an elected politician or a highly placed public official. In addition, there are situations involving public service agencies, many HRS agencies in fact, that are also enrolled as Medicaid providers. It has always been emphasized that there can never be any question of favoritism or special consideration shown to these kinds of facilities or providers or any others. As a matter of fact, quite the contrary. HRS has gone on record as insisting that departmental Medicaid providers should set the example for appropriate billing, policy compliance, and medical record documentation. In addition, precedents have been established that have subjected departmental providers to return overpayments with interest, pay fines, participate in provider education programs and be targeted for fraud investigations. Well meaning individuals may be guilty of an obstruction of justice by contaminating the administrative, civil or criminal proceedings by attempting improper influence.

Agency heads must buffer their regulatory personnel and insist on due process. External pressure must not be tolerated. The application of sanctions must be consistent across the board in amount, duration and scope, with the least amount of subjective discretion exercised.

Prepayment edits in the claims processing subsystem will not solve the problem. There is considerable confusion and downright naivete' regarding the ability of prepayment edits to prospectively monitor the appropriate utilization of the Florida Medicaid program. First of all, no editing system ever invented can deal with intentional deception. Next, it must be remembered that not all edits are considered fatal edits and that, for the most part, the edit system in Florida is designed to screen and filter claims for specific purposes. Some edits will deny a claim for obvious mistakes, others only pend claims for manual review, and still others are used to pay and list certain procedures or combinations of captured variables.

A number of knowledgeable systems workers have commented that systems edits are not, by definition, mutually exclusive edits.

Therefore, implying that the application of what seems to be unique edits in combination with other edits may yield totally unknown and certainly undesirable consequences that may impact on providers or recipients in ways never imagined.

Managed care strategies may not only not be the salvation for health care fraud and abuse issues; they may in fact create newer avenues of opportunity for abuse. There is always another end to the elephant and the managed care phenomena may not be the panacea health care planning advocates have presented it to be. An analogy: it is often suggested that individuals residing in democratic systems in desperate situations often turn to the knight waving the flags of totalitarianism in which change may occur overnight. The only price that must be paid for such change is one's popular sovereignty. In racing towards managed care changes the only price is the accountability and security of an audit trail. There are some very knowledgeable health reform advocates that are quick to point out that a movement from fee-for-service to capitation rates for managed care is like rearranging the deck chairs on the Titanic.

At the NASO conference for the last several years, there has been major concern over the creation of hybrid reimbursement models that have no baseline fee-for-service comparison. Cost based reimbursement models that are utilized without "looking behind the paper" are considered "prayer" models by regulatory investigators. There are any number of horror stories regarding managed care models. Two of the most infamous examples were the IMC fiasco in Florida and the Arizona Managed Care scandal.

Almost unanimously those individuals experienced in health care fraud and abuse investigations will state unequivocally that the movement from a fee for service reimbursement to some type of capitated arrangement does absolutely nothing to deter fraud and abuse; it just makes it more difficult to detect. The general consensus is that when the faucet gets turned off one place, it gets turned on somewhere else. What is likely to happen with more managed care emphasis is the creation of more sophisticated joint venture arrangements that will be well disguised and will promote recipient "ping-ponging" for a endless array of medically unnecessary services.

Medicaid Program Integrity's effectiveness can only be as good as the policy supporting the enforcement. At the core of policy compliance and regulation are the service coverages, limitations, caps, and exclusions. Other supporting criteria for standards of practice, quality of care and medical necessity need not necessarily be as specific as the policy unique to a particular program. No where is this better illustrated than in the concept of utilization control.

The term utilization control refers to procedures employed by health care professionals for the review and certification of the necessity, appropriateness, and quality of care provided to

Medicaid recipients. Utilization control is designed to influence utilization patterns in such a way that unnecessary or inappropriate services are minimized for any given benefit package. Utilization control is considered to be a primary element in Medicaid cost containment policy. Unlike benefit limitations or restrictions on eligibility, the recipient need not suffer any reductions in benefits if the program mechanism is properly administered. From a provider's perspective, utilization control does not have to result in lower levels of remuneration, as long as program standards are met.

The review procedures involve a number of different entities, varying according to the type of service being reviewed and the nature of the irregularity under review. The primary reviewing body within the state Medicaid agency in Florida is the Medicaid program integrity unit, which contains a detection section, two review sections and an administrative section. Other reviewing entities include the Medicaid fiscal agent contractor and agencies within and outside of the Department of Health and Rehabilitative Services (HRS/AHCA). Medicaid costs have escalated over the years for reasons such as reimbursement for services not rendered, reimbursement for services rendered by ineligible providers, referral kickbacks, excessive services, and a myriad of other irregularities. In addition to placing an additional financial burden on the Medicaid program, many of these irregularities also involve services that may be inappropriate or detrimental to the recipient's health and well-being.

Nevertheless, there is nothing more frustrating to a regulatory official than to observe and prove a gross aberration of policy compliance, only to be stymied by a lack of policy support to enable enforcement.

Resources For Fraud And Abuse are not necessarily difficult to obtain. Most public service entities have a built-in disclaimer when questioned about their inability to accomplish something or be held to certain accountability. Almost in unison one can predict the cry, "the legislature only funds this many resources to do the job". Prior to the 1993 legislative session, Medicaid took a totally new approach in contrast to traditional budget requests. The proposal aimed towards a zero-based budget concept with a phase-in strategy. The simplest description of this concept was that program integrity would fund and nurture itself based on its effectiveness. The ability to recoup overpayments, apply fines and charge investigative costs formed the basis of this funding strategy. Another feature that was appealing was that it was a pay-as-you-go strategy emphasizing a self-imposed growth rate to the point of diminishing returns.

The legislature liked the approach and found it difficult to oppose based on the fact that it was a needed resource, it required no new general revenue and it was based on a proven track record of over ten years' history. For every investigative position properly supported, a return of $250,000 can be anticipated. A result of

this strategy yielded 49 new staff for program integrity plus resources for a P.C. LAN network during the first phase of operation. Subsequent phases are anticipated once effectiveness can be documented.

Problem Areas And Potential Solutions

Problem: *At present, the Provider Enrollment Process performed by most Medicaid fiscal agent contractors is nothing more than a glorified clerical procedure. There is little, if any, initial screening of provider applicants. The only things that stand between a provider and the Medicaid cash vault are the provider enrollment process and the claims processing system.*

THERE ARE NUMEROUS EXAMPLES OF PROGRAM INTEGRITY'S SANCTIONING A PROVIDER WITH EITHER SUSPENSION OR TERMINATION ONLY TO DISCOVER THAT THE PROVIDER HAS RE-ENROLLED IN THE PROGRAM AND CONTINUED TO BILL INAPPROPRIATELY. THE PROBLEM IS MOST ACUTE WITH MEDICAL-RELATED CORPORATIONS OWNED BY NON-LICENSED PERSONS WHO ARE REALLY JUST ENTREPRENEURS THAT HAVE PROFESSIONALS WORKING FOR THEM AS EMPLOYEES. BOTH THE CODE OF FEDERAL REGULATIONS AND THE FLORIDA STATUTES REQUIRE OWNERSHIP DISCLOSURE.

Potential Solution: There should be a major reversal in the emphasis and philosophy in provider enrollment. Rather than put a premium on speed in the process, there should be an in-depth legitimate process installed that elevates the function from a simple clerical duty. At a minimum, there should be a Program integrity sign-off that would include a DPR review, an HHS review, Corporate Records and Ownership critique.

It might be appropriate to require that a performance bond be posted. Even low limits of $100,000 will cause an insurer to conduct a routine background (criminal) and financial check.

Problem: *Even under the best-case-scenario, the Medicaid reimbursement system and the Program integrity function will yield a pay-and-chase system. This one feature is probably the biggest shock to persons not familiar with the system. Rates are set for institutional providers based on unaudited cost reports. Years later audits may reveal overpayments. Other non-institutional providers such as independent laboratories or home health care agencies simply bill. Audits after payments may also reveal overpayments. The response is always the same, "We don't have it." Persons handling millions of Medicaid dollars and patients' lives currently do not have to be bonded; unlike someone painting a state-owned office building.*

Potential Solution: All non-institutional Medicaid provider applicants should be required to post a minimum $100,000 bond. The bond's amount should be increased if the billing per year exceeds that amount. Hospitals and nursing homes should post a $1 million dollar bond initially. The anticipated cost of the premium for a health care performance bond should not be high. For example, one home health care agency which employed only three full-time staff

had a $3 million dollar conventional insurance policy which cost $1,400 annually.

Problem: *Changes in corporate structure relating to a Medicaid provider's ownership or personnel are not reported promptly. While this may not necessarily be considered a major problem now, because of the ease of entry into the program, it is anticipated that it will become a significant problem once the requirements are tightened.*

Potential Solution: Provide in the Medicaid Provider Agreement, failure to report such changes within 30 days will result in a fine. Also make similar provision by statute.

Problem: *There are inadequate investigative resources throughout the various agencies charged with responsibilities in health care fraud and abuse.*

Potential Solution: Resource requests should be based on dollars recovered, fines applied and investigative costs imposed. This strategy allows appropriate growth on a pay-as-you-go approach. Eventually it could be almost entirely a zero-based budget with formula funding.

Problem: *Historically, the sharing and coordinating of information among various agencies with interests in such information has been less than ideal. The Health Care Fraud and Abuse Task Forces have contributed (to some extent) to more information sharing than ever before. The National Anti-Fraud Association has also taken some steps to create a national registry and clearinghouse. At this point, information in this system is not very timely. In addition, the National Association of SURS Officials has created an informal system that encourages sharing and review of common information. These are certainly means of sharing rudimentary information. However, the bottom line is that there is no systematic sharing of names of persons creating problems, details of schemes being used for fraud, or means of detection. Additionally, there are significant obstacles to such sharing of information presented by the public records act. If a corporation were suspected of false billing, any written record of that would be a public record and would have to be disclosed, even though no conclusion of false or fraudulent billing had been reached. This impedes investigation. Although Medicaid program integrity is somewhat shielded from this problem by special statute, the same is not true for other agencies involved in health care fraud and abuse.*

Potential Solution: There should be a statutory exception that would limit access to certain information under the public records law to any agency having jurisdiction over health care claims, civil or criminal.

Problem: *The Public Records Act is often used by litigants to bombard regulatory agencies with discovery requests which are not subject to normal limitations in the scope of discovery.*

Potential Solution: Once any person is identified as probably having submitted a false or fraudulent claim or otherwise having violated the law, public records requests should be subject to the scope of discovery, but only when our agency's decision or action has been reached.

Under the Federal APA, once litigation has commenced, a private litigant may not bombard an agency with public records requests. The same should hold true for our state APA, which for all practical purposes is a mirror of the Federal Act.

Problem: *The Florida Administrative Procedure Act affords certain aberrant providers an unusual and inappropriate degree of due process. There have been many times that program integrity has had knowledge and verification of actions taken by agencies with other jurisdictional responsibilities relative to/for provider action that are definite sanctionable offenses under this Medicaid program. Some call for immediate termination of the provider in question. Yet, under the Administrative Procedure Act, any action taken by an agency that affects the substantial interests of a provider is subject to an administrative hearing. In a worst case-scenario, you can have a situation in which you must continue to pay a known fraudulent provider for months without the ability to withhold anything more than 10 percent of the reimbursements while awaiting the outcome of an administrative hearing.*

Potential Solution: The state Division of Administrative Hearings should recognize that Federal Regulations 42 CFR 455.23 supersede the Administrative Procedure Act in this area, which allows the withholding of all claims for reimbursement if there is reliable evidence for fraud or willful misrepresentation. In addition, the state should pursue statutory language to enhance this position by mirroring the Federal language and also provide for an "*in camera*" hearing in order not to allow inappropriate premature discovery that might jeopardize later prosecutory efforts and keep paying a fraudulent provider. It might be appropriate for Federal regulations to specify that FFP is not available to states that pay such claims based on contradictory state statutory authority.

Problem: *A Medicaid provider agreement is viewed by the courts of Florida as a property right. Grossly abusive providers have, as a result, pre-termination rights to continue billing/stealing until terminated. In New York and the Second Circuit, providers do not have such a property right. Thus, they can be terminated first and then they must prove they were terminated wrongfully.*

Potential Solution: An amendment to Chapter 409 F.S. specifically exempting Medicaid Provider Agreements from APA procedures would provide a partial solution: 409.913(8) "Nothing in this Act shall be deemed to require the agency to proceed under the APA nor shall the agency be prohibited from pursuing any civil remedy under general law or statute." There is a broader perspective in view of health care reform that also should be considered.

Problem: *At the time the Administrative Procedure Act was created, no one envisioned the kinds of cases and dollar amounts that would be generated by the Medicaid program. Consequently, the APA requires state agencies to institute proceedings for overpayments and other sanctions, such as termination, in the Division of Administrative Hearings.*

Whether the hostility against agencies is exceeded by hearing officers' inability to grasp the supremacy clause is unknown. However, until Medicaid can bring certain selected actions in circuit court or federal court, there will be hindered progress in the war on health care fraud and abuse.

Potential Solution: Recently, Medicaid has filed civil theft and breach of contract actions in circuit court. They were dismissed because the agency, "had failed to exhaust administrative remedies." The case is on appeal to the First District Court of Appeal. Even if successful, the other four appellate districts would not be bound by the decision.

The APA needs to be amended to exempt any program receiving matching federal funds from having to proceed in the APA.

From speaking to Medicaid officers in other states, it would appear that the problem is not limited to Florida. Federal regulations should facilitate the ability of state-administered programs with federal money the option of bringing enforcement actions in state or federal court.

Problem: *The concept of venue for Medicaid actions represents a significant problem. Department of Administration (DOA) hearing officers routinely set final hearings in the county where the Medicaid provider resides. Additionally, provider circuit court actions are brought in the county where the provider is.*

Potential Solution: Venue in any action brought against any state agency with civil or criminal responsibility for violations of any program funded in whole or in part by federal funds should be brought in Leon county. This is certainly appropriate because this is where the claim was received, adjudicated and paid to the provider. This would greatly reduce the financial burdens to the state in terms of travel and other litigation expenses and not force state attorneys to have to argue away from the support of their offices.

A state venue statute would have to be passed. Venue for actions brought by state agencies should be in Leon County or where any defendant's transaction occurred. For example, a Miami (Dade County) provider might treat a Palm Beach County resident. Venue could then be in Palm Beach County.

Problem: *The legal remedies are not complete. While the Federal False Claims Act is effective it can only be brought in federal*

court. Historically, there has normally been a dollar threshold for such actions. Many state court attorneys are unfamiliar with Federal procedures, not admitted to federal court or not staffed adequately to meet the short constant deadlines and memoranda requirements.

Potential Solution: A state version of the Federal Act is being proposed by various state agencies. Hopefully, a state version will be enacted. Additionally, on the federal level, an amendment to the Federal Act which would allow cases under it to be brought in state court will help all of the states.

Problem: *Historically, there has not been a major emphasis placed on the collection of identified overpayments. There are any number of prime examples of large overpayments and agreements for repayment that have not been pursued when such repayments become delinquent. Ultimately, these amounts are written off as uncollectibles.*

Potential Solution: First, on every overpayment identified for a certain dollar threshold, say $2000.00, there should always be a corresponding judgment filed. Even if money could not be recovered immediately, it makes it difficult for the debtor to sell or transfer assets at a later time. In addition, some thought might be given to an aggressive collections effort by contingency agreements.

Problem: *Currently, the federal application and interpretation of the timing, as it relates to the identification of overpayments, is problematic to aggressive states that pursue with great vigor fraudulent and abusive providers. In effect, what the federal application does is to require the states to identify on the HCFA 64 reports those amounts, even preliminary amounts, not agreed-upon amounts, amounts where there has been no final agency determination and certainly no amounts that have been even partially collected. The liability to the state in these applications is obvious. The state ends up in a deficit posture after the initial notification to a provider of a potential overpayment.*

Potential Solution: Request exception to the federal application and interpretation, in order to release states from overpayment obligation until after a final agency action has been upheld and there is a definite obligation on the part of a provider.

Problem: *There are some competing forces at work regarding the approach to take on health care fraud and abuse initiatives. There are a number of unorchestrated efforts by various agencies aimed at dealing with health care fraud and abuse issues. With numerous jurisdictions, which forum or legal remedy, if any, is to be pursued, presents problems of coordination. This even assumes different agencies are unaware they may be working the same case. Unfortunately, due to a particular agency charge or a particular philosophical orientation or even jurisdictional requirements, there results a turf war. Certain investigative entities may*

compete by necessity based on the way they are routinely evaluated or funded. Others may be more politically motivated. Regardless of motives involved, the results are reflected in less than ideal cooperative agreements, inappropriate pursuit of certain cases, defensive posturing and, sometimes, clandestine maneuvering against other agencies.

Potential Solution: Although a certain amount of this competitiveness may be unavoidable, the realization that it even exists may be significant in itself. The various task forces that have been in operation during the past year are partial solutions to the problem. Through exchange of information and periodic meetings, problem providers can be identified and prosecution plans, if any, can be developed. Up to this point, there has not been a large referral of cases. This may be out of fear of losing turf. One solution is to permit many actions: Federal False Claim, Civil RICO and criminal. Of course, prosecution must avoid compromising criminal cases without permitting an uninterrupted cash flow to the defendant.

Problem: *There appears to be a reluctance, not in theory but on practical application, on the part of the states to participate with federal prosecutors in False Claims Actions. The simple reason for this reluctance appears to be that procedures have not been formalized for guaranteeing the states that the money recovered via this process will be shared with the state. This is extremely important to some states since much of their funding for fraud and abuse activities is received from this pot of money.*

Potential Solution: Codify in Federal Regulations a very simple procedure for cost sharing.

Problem: *Often in change of ownerships, in various institutional as well as non-institutional providers, a shell game occurs regarding the assumption of liabilities by the buyer. What many times happens is the new owners are, in fact, the same and, therefore attempt to exclude themselves from certain financial obligations.*

Potential Solution: Prohibit from Medicaid participation any provider not transferring liabilities to the new buyer at time of transaction.

Problem: *There is always the potential for various kinds of external influence when the stakes are as high as $7 billion in the Medicaid program and $10 million in the Medicare program. These and other federal and state programs create massive amounts of money which are targets for external pressure and manipulation by those with less than pure motives. The lobbyists have been active in attempting to direct certain outcomes in major civil cases.*

Potential Solution: Although it may not be a popular solution, it might be wise to consider the combination of a number of agencies involved in health care fraud and abuse issues into one single

unified agency which reports directly to the Governor and to a permanent Federal-State Task Force. There should be a number of separate and accountable checks and balances which would take the responsibility for settlement authority and sanction application out of any one individual's hands. This would go a long way towards improving the integrity of these responsibilities.

Problem: *There is no effective lock-in program for Medicaid recipients that are known abusers of the Medicaid program. There have been some concerns over the years with respect to recipient rights as well as a lack of appropriate systems to accommodate remedial action against such recipients. There has also been a history of challenges by Legal Aid to rules trying to set up such programs. Issues have been emerged regarding the concept of free choice of providers by Medicaid recipients.*

Potential Solution: Remove the smokescreen and install such a program regardless of concerns.

Problem: *There is a provision and a mechanism for both Medicaid and Medicare to cooperate with each other in collecting overpayments. This is not a mutually reciprocating in that it works considerably better for Medicare than Medicaid. The current process is clumsy, time consuming and extremely bureaucratic.*

Potential Solution: There needs to be some fast track mechanism developed via federal/state cooperation that facilitates this process for state Medicaid agencies.

Problem: *There has been a long-standing emphasis in developing intergovernmental financing strategies in this state to maximize federal financial participation via Medicaid and other federal funding. While this is certainly an appropriate and admirable strategy, there is sometimes a certain temptation to make things fit or appear to fit under federal programs that were never so intended. There have been several audit exceptions over the years that support this potential area of concern. In addition, there has been a certain philosophy that certain arrangements for FFP are good deals for the State never mind the Feds. That kind of reasoning is dangerously shallow.* There is a a standing joke among regulatory specialists that a synonym for abuse is "waiver".

Potential Solution: There needs to be an independent internal audit capability that incorporates program evaluation, funding shift arrangements, legislative intent, waiver projects and fiscal accountability. Emphasis should concentrate on those quasi-public organizational entities that are Medicaid providers, while at the same time having organizational and financial arrangements with the Department of Health and Rehabilitative Services as well as any other state agency.

Problem: *In criminal cases as well as certain civil actions, there are often stipulated agreements and pre-trial intervention agreements that are reached with providers that omit obligations on*

the part of the provider to comply with accompanying administrative requirements.

Potential Solution: Incorporate into inter-agency agreements the necessary protocols that would address these areas of concern.

Conclusion

Although the verdict is still out, there are appearances that serious thought is being devoted to issues related to health care fraud and abuse. If traditional approaches prevail during these debates, the outcomes are going to be disappointingly predictable. The Florida Medicaid program integrity unit has demonstrated for several years now that there are unique and innovative approaches to detection, investigation and penalty applications. There are also strategies that enhance prevention, cost recovery and cost avoidance. These approaches would seem to have immediate relevance and applications to other insurance programs beyond Medicaid. There are always some sacrifices and disadvantages associated with pioneering new strategies that threaten established institutional ways of doing things. Often those teetering on the cutting edge must be prepared for the criticism that naturally accompanies such agents of change.

The application of the TQM concept in the Florida Medicaid program integrity unit in the last few years has resulted in an environment that emphasizes creativity and welcomes new ways of trying things. For the past eight years, the Program integrity motto has been "Your imagination is your only stumbling block."

If real success is to be obtained in having a major impact on health care fraud and abuse it will come from strong administrative leadership that will be willing to deemphasize traditional criminal approaches and replace them with more high-tech solutions, like the application of artificial intelligence systems that will yield quick and effective remedies in the administrative arena.

SUPPLEMENT TO TESTIMONY

OF

JOHN M. WHIDDON, PROGRAM ADMINISTRATOR
FLORIDA AGENCY FOR HEALTH CARE ADMINISTRATION
MEDICAID PROGRAM INTEGRITY

FOR

CONGRESS OF THE UNITED STATES
HOUSE OF REPRESENTATIVES
SUBCOMMITTEE ON HUMAN RESOURCES
EDOLPHUS TOWNES, CHAIRMAN

FEBRUARY 25, 1994
MIAMI CITY COMMISSION CHAMBER
3500 PAN AMERICAN DRIVE
MIAMI, FLORIDA

Problem: Currently, federal regulations require states participating in certified Medicaid systems to have mechanisms for ex post facto review of potentially aberrant practices. This is an appropriate requirement, but the application of such traditional peer comparison models have become somewhat obsolete.

Potential Solution: Allow states greater flexibility for requesting waivers for functional equivalents to the requirements, when states can demonstrate more successful detection strategies via history of investigations and recoveries.

Problem: Federal regulations allow the withholding of payments to providers on the basis of reliable evidence of fraud or willful misrepresentation. This is a formidable weapon in the war against health care fraud and abuse. Unfortunately, there are instances when the "reliable evidence of fraud or willful misrepresentation" is possessed by an agency conducting a criminal inquiry. This creates a dilemma for the State agency responsible for determining appropriateness of payments because this evidence may not always be legally or responsibly shared. Protection afforded by due process and proper legal discovery may impair the ability of the State agency to completely and accurately present its arguments for withholding payments during an Administrative hearing. Premature revelation of critical evidence gained during a criminal investigation is, under currently applicable law and regulation, often ill-advised because it could jeopardize a successful prosecution.

Potential Solution: Modify the Federal Regulation 42 CFR 455.23 to allow an in camera inspection by the hearing officer or judge of the evidence to determine if the withholding of payments under the provision is justifiable.

Mr. TOWNS. Thank you very much, Mr. Whiddon.
Mr. Morris.

STATEMENT OF JOHN G. MORRIS, JR., DIRECTOR, FLORIDA MEDICAID FRAUD CONTROL UNIT

Mr. MORRIS. Mr. Chairman, members of the committee, as director of the Florida Medicaid Fraud Control Unit, I am very pleased to appear before you today to discuss fraud and abuse in the Medicaid program within the State of Florida.

As Congressman Mica indicated earlier, the budget for the current fiscal year in the State of Florida is approximately $6.4 billion. And again, using that GAO statistic of approximately 10 percent, it is easy to estimate the fraud this year could be as much as $640 million.

In 1980 when the Florida Medicaid Fraud Control Unit was created or established, the entire budget for the Medicaid program at that time was approximately $550 million. As you can see, in a mere 13 years, the fiscal year fraud—excuse me, the fraud this year will be more than the budget was a mere 13 years ago.

The past decade has seen a drastic increase in the Medicaid program, both in benefits and in recipients and dollars available to be expended on their behalf. With the increase in these benefits and dollars, there has been a corresponding increase in fraud and abuse that has swept through the various programs in Medicaid. The large increase in dollars has certainly encouraged the profiteers to use every innovative scheme available to maximize the dollars they can get from the Medicaid program.

Having had the opportunity and pleasure of serving as director of the Medicaid Fraud Control Unit since its inception in 1980, I have seen many of the various schemes used by the various providers. A few typical examples include falsification of nursing home cost reports, falsification of mileage and trips by transportation providers, pharmacies billing for medications when they in fact have dispensed nonpharmaceutical items such as tennis shoes, or in one case a grandfather clock. Other examples include home health providers billing for deceased patients, dentists billing for a three surface filling when in fact only a one surface filling has been filled. And the list can go on and on and on.

The State of Florida is not unlike any other State in the amount or degree of fraud or abuse in the Medicaid program. While there may be variations on how the fraud is committed within this State, the concerns or problems associated with the detection, investigation and prosecution are pretty much the same throughout the country.

As indicated by one of you on the committee, one of our primary concerns that is faced by all of us in the investigation and prosecution of health care is the lack of resources available. To illustrate what resources are needed, let me briefly describe a case involving an individual by the name of Imo John Akpaeti. This case was initiated by the Medicaid Fraud Control Unit in April 1990. The investigation developed into a cooperative effort with the investigative resources being provided by the Federal Bureau of Investigation, the Department of Health and Human Services Inspectors General's Office and the Medicaid Fraud Control Unit.

The investigation was completed and the case was forwarded to the U.S. attorney's office in October 1991, approximately 18 months later. In December 1992, the defendant was charged in a 40-count indictment with five counts of mail fraud, 35 counts of filing false claims against the United States. The indictment alleged that the defendant owned and operated International Humanity Health Services, Inc., a home health agency located in Miami. From approximately March 1989 through June 1990, the defendant engaged in an ongoing scheme to defraud the Medicaid program by filing false claims for home health services which were never rendered. In some instances, the defendant billed Medicaid for nursing services rendered by registered nurses who never worked at International Humanity. In other instances, the defendant billed Medicaid for services purportedly rendered to patients who were in fact deceased. As a result of these false claims, the Medicaid program paid in excess of $350,000 in false claims during the 15 month period under review.

In September 1993, after a 1-week jury trial, the defendant was found guilty on all 40 counts. On February 14 of this year, approximately 2 weeks ago, the defendant was sentenced to serve 71 months in a U.S. prison facility followed by 3 years of probation and ordered to pay restitution of approximately $115,000.

As you can see from this example, it took almost 4 years and the efforts of three investigative agencies, the U.S. attorney's office, a Federal grand jury, a trial jury and a judge to convict this single provider. The scheme used by this individual provider was by no means a sophisticated scheme. Had it been, the number and experience level of the resources needed would have been even greater.

While the theft of this $350,000 is certainly not a small amount, it is certainly nowhere near the amount that has been identified in some of the major cases around the country, and it certainly is a very small percentage of the millions of dollars that are stolen annually in the State of Florida. As you can see from this one example, it takes a great deal of resources to investigate and prosecute, and to increase this to the $640 million level estimated, it would take a potentially greater number of individuals.

Another major and related concern that I would like to share with the committee is my fear that the issue of fraud and abuse will not be fully addressed in the development of a national health care plan. No matter what health care plan is ultimately adopted by Congress, there will be fraud committed by a number of unscrupulous providers.

Unfortunately this small percentage of individuals will do everything within their power to devise ways to beat the system. One quick example of the new threat that is faced is in the area of computerization. As our society moves further into the computer age, we develop newer and faster ways to process our health claims and receive payments. We also unfortunately provide newer and faster ways to steal from the system.

With the development of electronic data interchange, we are providing an ideal opportunity for a hacker, for example, to enter a computer system, install himself as a provider, submit false claims, provide for electronic transfer of funds to his own bank account. The entire process could conceivably take less than a few minutes

and the individual could be millions of dollars richer. As you know, hackers have already broken into some of our most sophisticated computer systems.

In conclusion, I would like to say that no matter what health care plan is ultimately adopted, it must be recognized that there will be fraud and abuse in the program. It is not going to go away, and to combat this fraud and abuse, it is necessary that we have dedicated resources to fight it.

Mr. Chairman, I thank you for the opportunity to testify today and I will be happy to try to answer any questions you may have.

[The prepared statement of Mr. Morris follows:]

TESTIMONY

JOHN G. MORRIS JR., DIRECTOR

MEDICAID FRAUD CONTROL UNIT

MEDICAID FRAUD AND ABUSE IN FLORIDA

CONGRESS OF THE UNITED STATES

SUBCOMMITTEE ON HUMAN RESORCES

AND INTERGOVERNMENTAL RELATIONS

FEBRUARY 25,1994

Mr. Chairman, Members of the Committee

As Director of the Florida Medicaid Fraud Control Unit, I am very pleased to appear before you today to discuss fraud and abuse in the Medicaid program within the State of Florida.

The Medicaid budget for the current fiscal year in the State of Florida is 6.4 billion dollars. Using the recent General Accounting Office estimate that 10% of health care is lost to fraud and abuse it is easy to calculate that the lose in Florida this year would be approximately 640 million dollars.

In 1980 when the Florida Medicaid Fraud Control Unit was established the State of Florida expenditures for the entire Medicaid program was approximately 550 million dollars. Which means that during the current fiscal year we will loose more to fraud and abuse than was spent for the entire program a mere 13 years ago.

The past decade has seen a drastic increase in the Medicaid program both in benefits available to recipients and dollars expended on behalf of these recipients. With the increase in benefits and dollars, there has been a corresponding increase in fraud and abuse that has swept through the various programs in medicaid. The large increase in dollars has certainly encouraged the profiteers to use every innovative scheme available to maximize the dollars they can get from the medicaid program.

Having had the opportunity and pleasure of serving as Director of the Florida Medicaid Fraud Control Unit since its creation in 1980, I have seen many of the various schemes used by Medicaid providers. A few typical examples include falsification of nursing home cost reports to increase the per diem rate, falsification of mileage and trips by transportation providers, pharmacies billing for medications when they have dispensed non-pharmaceutical items such as tennis shoes or in one case a grandfather clock. Other examples include home health providers billing for deceased recipients, dentists billing for a 3 surface filling when only a one surface filling is used, and the list goes on and on.

The State of Florida is not unlike any other state in the amount or degree of fraud or abuse in the Medicaid program. While there may be variations on how the fraud is committed the concerns or problems associated with the detection, investigation and prosecution are the same throughout the country.

One of the primary concerns that is faced by all of us associated with the investigation and prosecution of health care fraud is the lack of resources available. To illustrate the resources needed, let me briefly describe the case against an

individual by the name of Imo John Akpaeti. The case was initiated by the Medicaid Fraud Control Unit in April of 1990. The investigation developed into a cooperative effort with the investigative resources being provided by Federal Bureau of Investigation, The Department of Health and Human Services Inspector Generals Office and the Medicaid Fraud Control Unit.

The investigation was completed and the case was forwarded to the U.S. Attorney's Office in October of 1991. In December of 1992 the defendant, Imo Akpaeti, was charged in a 40 count indictment with 5 counts of mail fraud and 35 counts of filing false claims against the United States. The Indictment alleged that the defendant owned and operated International Humanity Health Services, Inc., a home health agency located in Miami. From approximately March of 1989 through June of 1990 the defendant engaged in a scheme to defraud the Medicaid program by filing false Medicaid claims for home health services which were never rendered. In some instances, the defendant billed Medicaid for nursing services allegedly rendered by registered nurses who never worked at International Humanity Health Services, Inc. In other instances, the defendant billed Medicaid for services purportedly rendered to patients who were in fact deceased. As a result of the false claims, the Florida Medicaid program paid in excess of $350,000 in false claims during the 15 month period under review.

In September of 1993, after a one week, jury trial the defendant was found guilty of all 40 counts. On February 14th, 1994 Imo Akpaeti was sentenced to serve 71 months in a U.S. prison facility followed by three years of probation and ordered to pay restitution of approximately $115,000.

As you can see from this example, it took almost 4 years and the efforts of 3 investigative agencies, the U.S. Attorneys Office, a federal grand jury, the trial jury and a judge to convict this single Medicaid provider. The scheme used by this individual was by no means an extremely sophisticated one, had it been, the number and experience level of the resources needed would have been even greater.

While the theft of $350,000 is not a small amount it certainly is nowhere near the amount identified in some of the major cases around the country and it is a very small percentage of the millions of dollars that is stolen annually in the State of Florida. As you can see the resources needed to identify, investigate and prosecute the $350,000 identified in this case would need to be increased several times if we intend to address the potential $640 million in fraud and abuse I identified earlier.

Another major and related concern that I would like to share with the committee is my fear that the issue of fraud and abuse

will not be addressed fully in the development of the national health care plan. No matter what health care plan is ultimately adopted by congress, there will be fraud committed by a number of unscrupulous providers.

Unfortunately, there is a small percentage of individuals who will do everything within their power to devise ways to beat the system. One quick example of the new threats that is faced is in the area of computerization. As our society moves further into the computer age, we develop newer and faster ways to process our health care claims and receive payments. We also are unfortunately providing newer and faster ways to steal from the system.

With the development of Electronic Data Interchange (EDI) we are providing an ideal opportunity for a hacker to enter a computer system, install himself as a provider and then submit claims which provide for electronic transfer of funds to his bank account. The entire process could conceivably take less than a few minutes and the individual could be millions of dollars richer. As we know, hackers have broken into some of our most sophisticated computer systems.

In conclusion I would like to say that no matter what health care plan is ultimately adopted, it must be recognized that there will be fraud and abuse in the program, it isn't going to go away. To combat this fraud there must be sufficient dedicated resources available at all levels, the state and federal, public and private.

Mr Chairman, I thank you for the opportunity to testify today and would be happy to try and answer any questions you may have.

Mr. TOWNS. Let me thank you, Mr. Morris, and let me thank all of you for your testimony.

Let me begin by first trying to clarify something that is not quite clear to me.

Mr. SCHIFF. Mr. Chairman, excuse me.

Before you begin your line of questioning—thank you for yielding—at this time, it is necessary that I find a phone and call Washington to resolve a matter there in my office. If I do not return in a few minutes, I would yield any questioning time I have to Mr. Mica for his questioning, with your consent.

Mr. TOWNS. Be delighted to recognize that request.

Let me—you talked about a work study group and then I heard the word "task force." Is that the same thing?

Mr. WHIDDON. No.

Mr. TOWNS. What is the work study group, what does it consist of, and the formulation of it, how did it come about?

Mr. NOBLE. Mr. Chairman, the task force that we referred to is basically a task force that was initiated a couple of years ago by Governor Chiles in conjunction with the Attorney General to bring together Federal and State enforcement resources to work together to prosecute and support the effort to prosecute and share information, share resources in prosecuting of Medicaid fraud cases.

In the Florida health care reform bill at the State level that was passed last year, one of the requirements in that bill requires the Agency for Health Care Administration to put together a number of different work groups covering a number of subjects in the health care area. Health care fraud and abuse was one of those subjects. A work group was put together, composed of a number of different State agency representatives, insurance carriers, private entities. The U.S. attorney's representatives participated, State attorney's office, to come up with recommendations to be submitted back to the legislature in our Florida health plan to deal with providing recommendations, proposed legislation and a number of other topics just dealing with health care in general, health care fraud and abuse.

Mr. TOWNS. Thank you very much for the clarification.

Let me just begin with you, Ms. Aronovitz. You described in your testimony several individuals and pharmacists charged with Medicaid fraud in Florida and yet they continued to participate in the Medicaid program. Which agency in Florida is responsible for ensuring that people excluded from the Medicaid program do not continue to participate in the program?

Ms. ARONOVITZ. I think some of the gentlemen sitting at the table could probably answer that more specifically, but it does involve coordination between quite a few organizations, including the State licensing boards. And one of the problems that we found is that—even with a better law, to immediately require a convicted felon to lose his license—it is very difficult sometimes for the State Medicaid agency to communicate and to get that information to the licensing board, and then the licensing board needs to take action through a due process procedure with appeals, to assure that that person gets eliminated from the program.

Even when that happens, it is not always clear that the person who was excluded from participation in Medicaid cannot reappear or surface in some other form.

We have one example where a pharmacy was charged with fraud and they closed down—the State closed down that pharmacy, in three cases we found, two opened up with another corporate name and a different owner but the same exact pharmacy and very possibly the same people. In one of those cases, we found that the pharmacist who used to be the owner, was no longer the owner but was still the pharmacist working in the pharmacy. And in another case, the pharmacy reopened in the spouse's name.

So there are a lot of loopholes for people who really want to make their business Medicaid fraud, and it is not that easy to coordinate and assure that people are summarily removed from the program on a consistent basis.

Mr. TOWNS. You know, this really bothers me because——

Ms. ARONOVITZ. It is outrageous.

Mr. TOWNS. Yeah, what you are saying is that, for instance, if I am licensed in Florida and I am licensed in Georgia, that if you catch me in Florida, I can go practice in Georgia.

Ms. ARONOVITZ. HCFA, the Health Care Financing Administration, does have a bulletin or a list that they put out that is supposed to inform various States of actions that have taken place in other States. This list is not always up to date, it is not always used, it is sometimes incomplete, and also the information is not typically updated on an ongoing basis. So in theory, HCFA is supposed to be helping out in this regard, helping States, but it does not always work out that way.

Mr. TOWNS. Yes, sir?

Mr. NOBLE. Mr. Chairman, Ms. Aronovitz, the statement she has made, are real examples of problems we have in the pharmacy area. In terms of the licensure responsibility in Florida, the Department of Professional Regulations currently has that responsibility. One of the provisions of our health care reform act transfers responsibility for the medical quality assurance oversight, board oversight, of most of the health care professionals to the Agency for Health Care Administration this coming July. That issue is being debated again in the Florida Legislature. There are significant problems in terms of—or considerations in terms of—in the licensure arena where we currently have—they still go through an extensive due process type of arrangement before a license is removed.

Mr. TOWNS. Mr. Whiddon.

Mr. WHIDDON. Mr. Chairman, you have hit on a very interesting dilemma that we face. Some of the biggest health care fraud and abuse schemes or scandals or scams that we run into, there is no direct relationship between, a license and a licensed provider and an enrolled Medicaid provider. Some of the biggest problems that we have are with individuals that do not have any form of a license at all. They are entrepreneurs who simply have legitimate licensed providers under their employ.

Mr. TOWNS. You know, I am just sort of thinking this through and my time has expired, I am going to yield to my colleague in a second, but here we are getting ready to reform health care and

having these kind of problems, I do not care how much money we put into it, you know, it is just like an empty hole, it is going to fall out and nothing is going to happen. I think that we have to some way or another, you know, tighten it up before we can move it forward. I sort of do not understand in terms of our thinking, you know, when I look at even in your situation here, when you talk about the amount of money that you were able to recoup, and at the same time you talk about the shortage of staff and to be able to aggressively kind of pursue these things, you know. And then of course one would wonder, you know, why can we not recognize the fact that this is a very serious problem and from an economic standpoint, that we really cannot deal with the 38 million people that are uninsured until we begin to do something about this abuse. And I think just to be able to coordinate it in a way that if a person is caught, and then that person was convicted, that that person is out of the program. I think that is something that we should be able to do.

Now I can understand in terms of investigation and how long it takes and how the case can do this and take funny kind of turns on you in the process of you trying, but when there is a situation where a person has been convicted and they are still able to participate in the program because of all the kind of agencies and—this is the same country that can put a man or woman on the moon. There seems to be something wrong with this.

What suggestions do you have for me? Switch seats for a second. As a Member of the U.S. Congress, chairman of the subcommittee that has jurisdiction, what can we do as we move now to health care reform—what are some of the suggestions and recommendations you might want to make to me and this committee.

Mr. NOBLE. I have a couple of suggestions. You touched on some of the problems that we have. I think in the Florida health care reform plans, the State, our Agency for Health Care Administration, for the first time with the current structure, we will have under one roof all of the entities that would be responsible for the planning, coordinating and licensing, regulating health care professionals, health care industries. That is a significant step.

In terms of, at the Federal level and also at the State level—I mentioned in my testimony our Federal False Claims Act, we feel like the more aggressive prosecution in terms of civil penalties incorporated in that act, there are treble damage provisions where less emphasis on criminal prosecution—Mr. Morris cited the length of time to build a case and the amount of the restitutions, we feel like strengthening the provisions to shut off an abusive or fraudulent provider's payments going out the door would save or cause to avoid significant dollars. And then strengthening provisions in terms of licensure once a provider is convicted of a felony. And one of our provisions in our proposed statutory changes this year is for any felony to be looked at. One of the things that we have been looking at in the past is just health care related crimes. We find that a number of providers have been convicted of other types of felonies—we are not saying all felons, but in recognizing certain rights being restored, that sort of thing—but we feel like strengthening those types of things would act as a significant deterrent in the wars that we are facing.

Mr. WHIDDON. Mr. Chairman, specifically there are some things that in Florida we have to do to clean up our own house. And we are in the process of trying to plug some of those loopholes in oversight legislation right now, State statute 409–913, which is the Medicaid Program Integrity oversight, is quite frankly probably the strongest one in the country right now, but we have tried to make some additions to it this year to even strengthen that based on some problems, case study type examples that we have.

But at the Federal level, there are some things, Federal regulations, that stand in the State's way that would be of significant help if you could do something about those.

Very quickly, if we could establish some type of a fast track system to put liens against Medicare funds to providers—we have that mechanism in place, it works a lot better from the Medicare side of the house than it does from the State side of the house. If we could implement a fast track procedure, that would certainly help.

The second thing that would be of significant help would be a prohibition or withholding of FFP from States that have either contradictory statutory authority related to the withholding of payments on the basis of fraud or willful misrepresentation, when there is reliable evidence that this is occurring.

If that regulation could be strengthened to force the States to comply, that would in fact facilitate the States' ability to make those withholdings.

Right now, we can see examples when we know we have a bad provider, we, the State agency, are not in possession of reliable evidence, we know that he is under investigation, we see thousands and thousands of dollars going out the door while a criminal investigation is ensuing. We do not have an effective mechanism to really stop that.

The third thing is if a very simple cost-sharing formula could be put in Federal regulations regarding the ability of the States to participate with the Federal Government on civil false claims act recoveries—if that could be done, there would probably be a greater incentive for the State to utilize that mechanism.

Another thing is that, under the Federal requirements for surveillance utilization and review mechanisms the State must have, the requirements are obsolete and it is very difficult for States to convince the Federal authorities that there are functional equivalents that are far more effective for targeting health care fraud and abuse. The resources that are being devoted to those old traditional mechanisms could be converted into investigative capabilities and better detection, and not have to be used in the manner that they are now.

Mr. TOWNS. Thank you.

Ms. ARONOVITZ. I would like to say that I think you have really hit on some very, very critical points. Just in our study, in Florida, in 1990–91, we tried to identify cases where people were charged and convicted of drug diversion. Now of course, there are lots of other types of fraud, but we found nine cases. And of those nine people which had professional licenses, six of them never had any licensure action taken and of the other three that did, the most severe penalty was 1 year probation. Now this was again, 1½ years ago, based on cases in 1990. So now I believe things have been

stricter. But at the Federal level, one of the issues that we have been pressing on for a long time, not just in our work in Medicaid, but also in the Medicare area, really has to do with the way resources for safeguard activities are allocated. And basically right now, resources for the Inspectors General and other investigatory agencies really do not have a separate line item, or those resources are not protected. So there is not the acknowledgement that if you commit resources to safeguard activities, that you will get that money back two, three, tenfold. Right now what happens, especially—most of my knowledge is in the Medicare program—most of the money that is set aside for safeguard activities for investigations into fraud, that money or that budget competes with other funds for food stamps and any other of the domestic programs. So what we have been advocating for a long time, either through the budget enforcement act or some other mechanism, is to try to separate out a line item for investigative resources so that as program budgets increase, the investigation agencies do not find their budgets decreasing.

Mr. TOWNS. Thank you.

I am going to yield to my colleague from Florida, who has really been very aggressive on this matter in Washington, DC. We appreciate his leadership, and at this time, I yield to him.

Mr. MICA. Well thank you, Mr. Chairman. Again, I cannot thank you enough for coming and conducting this hearing today. I have been involved in Florida politics for 20 some years and business and other things, in and out of politics, did investigative work at the local level. And I am telling you that I have never seen anything that will have the impact of what you have done in stirring this matter up. And I appreciate your participating in this.

You know, from the hearing in August in New York, when we first did this, you can hear what has taken place. Now we have never talked to you gentlemen before and everyone of you have really the ability to help us mold and shape whatever is going on in this State and this program. But I am telling you, you will probably make the most substantial impact in this State in saving the taxpayer money in what you have already done and the attention you are focusing on this today. You got the Governor's attention, you got the State legislators' attention, the attorney general of the State's attention. And first of all, I want to thank you all for what you have done just since we have sort of brought this to the forefront, because you have made an impact already.

Reporting to us shows we have still got a ways to go. Mr. Whiddon, this is an incredible document that you prepared, and I salute you for that. It is really sort of a handbook to sort of undo the mess of fraud and abuse and the disorganization in this. And I am going to ask our staff too to go through this, and we need to keep the pressure on the legislature who are meeting right now. Many of these are State recommendations. I read through it carefully this morning, but I compliment you on taking this apart and with your expertise in doing these things.

Now we could spend hours and hours going over your document, but again, I thank you on the complexity of it. And you went through and gave specific solutions.

Now Mr. Noble also, I guess this is a handbook for you too, as you try to undertake improvements. As many recommendations as are in here, you have raised a number of questions, some of them contrary to what has been reported by the media—help is not on the horizon. You do question too the—I guess they brought in 10 FBI folks under the U.S. attorney's office and you do not think that that is going to be that effective. At the Federal prosecutorial level, how do you think we should proceed in this manner? Now some of it goes into, you know, the codification of some of the Federal regulations to cost-sharing, you gave a recommendation to liens against certain providers, I guess. From a prosecutorial standpoint, how should we be proceeding? Are we heading down the wrong path here?

Mr. WHIDDON. First of all, let me make sure that—there is no intention whatsoever to take a shot at the FBI in this document. Your question could more appropriately be answered by someone in the next panel, Jeanne Damirgian, who has probably had more success than anybody in the State of Florida in prosecuting health care fraud.

My major point and the emphasis with respect to the FBI or anybody else that is brought in, is that it does in fact require a totally different type of training to conduct health care fraud matters and investigations, and certainly—see, the consequence of solicitation, which is a type of recruitment or the use of a Medicaid recipient's card for benefits, the consequence of that action is normally a medically unnecessary service. So what you have immediately there is a false claim. Now you may be able to prove that it is fraud, but probably not. There is going to have to be some virgin territory plowed here, and I think probably Jeanne Damirgian could probably speak to that more effectively than I can.

Mr. MICA. Another point that has been discussed is that—well first of all, all the fraud is not just the big fraud that we have talked about. A lot of it is in the whole simple process, and with 1.6 million people involved in this and applying for this or participating in it, it does not seem that there is a good mechanism to prescreen these people. It is my understanding in New York, they adopted a photo ID program and that was recommended in Florida but not instituted. So what is your feeling on this, and the status? Is this something we should be looking at and instituting?

Mr. WHIDDON. Are you addressing it to——

Mr. MICA. Anyone, except for Ms. Aronovitz.

Mr. MORRIS. Congressman, I would certainly think it would be beneficial if it was done in the State of Florida. It is a very costly procedure, I understand, to do it. But from an investigative standpoint, I think dealing with an individual who walks in with a photo ID, it is a lot more difficult to pass ID cards back and forth and to pass eligibility around, and I think it would, to a certain extent, help the provider in identifying the individual. I do not think it is going to drastically reduce provider fraud but I think it would help more at the recipient level.

Mr. MICA. On the recipient, but with 1.6 million, you pointed out that it is not all just the big boys who are ripping off the system, that we need to look at it from the very inception where there is, you know, someone applying for this assistance and not carefully

screened. So you want to get both approaches. So maybe at the Federal level, we are not making, say, restrictions or guidelines to ensure that there is some protection from the very beginning in the system.

Mr. WHIDDON. You are absolutely correct. Interestingly enough, solicitation has formed a whole new industry in south Florida with Medicaid recipients. They have become drivers and solicitors themselves and many of them have income that would certainly make them ineligible for Medicaid if they were to report such income. But we know since they in fact have knowledge of where Medicaid recipients live, where they are housed, where there are great concentrations, they cart them from one doctor to another for finder fees that range anywhere from $10 to $15 to $125 and many times those are converted by unscrupulous providers into thousands of dollars of medically unnecessary services.

Mr. MICA. One of the complaints that we heard before was that Florida did not have adequate funding for Medicaid fraud unit activities. I was shocked to learn that the Federal Government pays 75 percent of the tab, the State only pays 25 percent of the tab. And what is the situation now, these 49 new positions in Florida, how are they being funded and is it my understanding too that you are looking at additional funding from the Federal level, and do you find Federal level funding adequate for your needs—if you are going to get involved in pursuing this stuff, are we doing a good job at the Federal level in providing the resources?

Mr. NOBLE. In response to the 49 positions, those positions were allocated to the Medicaid Program Integrity, the State agency. Now those positions were 50 percent State funded, 50 percent federally funded. We found, as I stated in my testimony, that the program integrity unit is cost effective, and we are basically at the point where we are self-supporting in terms of recoupment.

Mr. MICA. What is your budget for last year as opposed to what you are proposing for the Medicaid Fraud Unit in Florida?

Mr. NOBLE. Mr. Morris can address the fraud unit.

Mr. MORRIS. The current budget for the State of Florida for this fiscal year provides for funding for 49 positions. The request pending before the legislature at the present time would provide for an additional 15 people to be added to the fraud unit.

Mr. MICA. What about dollars? Is that the 75 percent Federal money?

Mr. MORRIS. Yes, sir, we receive 75 percent from the Federal Government through HHS. Under the Medicaid Fraud Control Unit program, the Federal Government provides 90 percent for the first 12 quarters, and after that then it drops to 75 percent.

Mr. MICA. So you will have a total of 64 people, if——

Mr. MORRIS. If it is approved, that is correct.

Mr. MICA. In New York, when we looked at New York's system, they had about 300 people and 150 of those were I think in New York City. Is this effective, Ms. Aronovitz?

Ms. ARONOVITZ. I definitely think that any resources put toward the Inspectors General activities and also program integrity unit and also Medicaid Fraud Control Units the MFCUs, it is critical that they are adequately funded. I do not think that any of the gentlemen at the table would say that they currently or in the fu-

ture will be adequately funded, but I think every position gets them closer to being able to do more in terms of investigations. I do not think you will ever be able to adequately fund units that are so cost effective, but that up front require some contribution. But I think this is definitely a step in the right direction.

Mr. MICA. Have you reviewed what the FBI and the U.S. attorney's office is doing here? Are you familiar with that enough to comment? I know it is relatively new, but there seems to be some disagreement as to its effectiveness.

Ms. ARONOVITZ. We have not looked at the new FBI initiative, but one of the things we did check, when we were looking at cases in Florida that the MFCU was working, to find out how many people were charged or convicted of drug diversion in 1990–91, we tried to see or talk to the U.S. attorney's office to see what they were doing.

Mr. MICA. There was nothing happening the last time.

Ms. ARONOVITZ. Right. And the reason for that is that they are so involved in illicit drugs—now this is a new initiative and something we will look at, maybe a year from now, but——

Mr. MICA. Has the U.S. attorney's office been in consultation with your offices on this matter? Because see, you know, we are here from the Federal level and we would like to raise hell about getting attention to these problems, but we want it to be the right attention. And we were shocked to find that the U.S. attorney's office was doing really nothing. Now they are jumping into this. We want to make certain that what they are doing in Florida is cost effective and effective and directed and that they have got the right people. And be honest with me, tell me if what they are doing needs to go in some other direction, because this is the panel that can take those resources and direct them or ask that they be directed in a cost effective manner.

Mr. NOBLE. Mr. Mica, I can say that since I have been with this agency, the U.S. attorney has been participating in our work group, our task force. We found the caseload has been heavy, particularly here in the southern district.

Mr. MICA. The other thing too—I am sorry, go ahead, Mr. Morris.

Mr. MORRIS. Congressman, I would like to point out that during the last 18 to 24 months, the cooperation and degree of effort put forward by all three U.S. district attorneys' offices—U.S. attorneys offices has drastically increased. We have found that the cooperation with the Federal Bureau of Investigation, the U.S. attorney's office has made things a lot more efficient in our prosecutions. That is not to say that we have got enough resources, but——

Mr. MICA. Now the last time we talked, the problem was in south Florida, the pill mills and the ripoff schemes and the provider-oriented white collar crime was here. Is that still the case?

Mr. MORRIS. I believe—the gentleman could correct me, but approximately one-third of the total budget goes into Dade, Broward, and Palm Beach Counties, so yes, the major problem is still here in south Florida.

Mr. MICA. And of the new resources that are coming, most are going to be directed down here where we have got that problem?

Mr. MORRIS. As far as my unit is concerned, that is correct.

Mr. MICA. OK, and are any of the other U.S. attorney offices pursuing this, or is this only under this southern district of Florida?

Mr. MORRIS. Both the middle district and the northern district have committed individuals.

Mr. MICA. What about the middle district?

Mr. MORRIS. Yes, sir, the middle and the northern both have committed individuals to health care fraud.

Mr. MICA. OK.

Mr. WHIDDON. In addition, one thing that has been discussed, since there are much fewer cases in the northern district, the U.S. attorney's office up there has been very interested in pursuing, you know, additional work in the south Florida area, and currently have a major case going on in that area.

Mr. MICA. If I may, Mr. Chairman, I think Mr. Schiff gave me his time—the other thing that concerned us, the initial reports that we heard is very few people were going to jail. Now you gave one illustrative example of a case that was pursued. Are we really making progress in this area or is no one still—I mean, was this one example of where somebody is going to jail? The initial information our subcommittee had was nobody was serving any time, nobody was serving jail time. And the other part of this was the same people were in business. They would go out and they are conducting business under some other name and I think that I had heard somewhere that there are people in south Florida who are involved in sort of a shell game, they would be closed down in one area and then pop up in another area, so they are ripping off the system under pseudo names. What is the status on this?

Mr. MORRIS. As far as the prosecutions are concerned, under the current Florida sentencing guidelines, the likelihood of a provider here who is a first time offender going to jail is very small. We have, however, found that the likelihood of a first time offender in the Federal system going to jail is much greater, and in fact, as I indicated in this——

Mr. MICA. That is one reason why we talked about increasing Federal prosecution. The original testimony that we had, Ms. Aronovitz, was that they had statutes that they could go after them, but there was nothing being done from the prosecutorial standpoint. I am sorry, I did not mean to interrupt.

Mr. MORRIS. Well what I am saying is that we have had much greater success in the Federal system in getting people convicted. The last two convictions, for example, the one I just recited, sentencing 2 weeks ago; a recent one in Panama City, FL, a doctor was convicted, he is facing some jail time. So in the Federal system——

Mr. MICA. So we are getting the message out that if you rip off the system in a criminal fashion, you cannot conduct business as usual down here.

Mr. MORRIS. Especially in the Federal system. If it is in Federal court, the likelihood of jail time is much greater.

Mr. MICA. Well you know, again, I cannot thank the three of you enough for your participation, what you have done so far. Our intent in being here is to be constructive, to make sure that you have the resources and the tools and that what we do from the Federal level is in a productive and constructive fashion. As somebody said,

you have the potential for getting back 20 percent or something like that, return of the budget, or the recovery is adding back to that money. That—we are talking phenomenal amounts of money here, and so if we can be effective together—but I would ask you to be a conduit to this subcommittee in anything you see at the Federal level, anything we can move. Now we have got a real big experiment going on here with a new health care system in Florida, and we do not want to repeat the mistakes of the past. The chairman specifically asked for recommendations from any of the Florida people. You are going to be sort of the pioneers in this, you are pioneers in it. And some of what is taken from Florida may be extrapolated and incorporated into a Federal program. But we do not want to take any of the bad that we have had or things that have gone undone. And we will take this information back again.

I have never seen anything like this prepared for our subcommittee, Mr. Whiddon, I can congratulate you. The parts in here that relate to the State, I guarantee you that we will be back to the Governor, to the legislative leaders, in fact next week, with this information, with your recommendations, and again working together. I mean, we look like mean guys, but we have got a lot of potential to make some incredible changes in a $6.5 billion program in the State, and what we get in the future is going to be very dependent on our success and how we handle this.

So again, I thank you. I am sorry, Mr. Chairman, I have gone over, but again, I commend you on what you have done here today and what you are doing to keep this moving at the Federal level.

Specific Federal recommendations too, we will ask the subcommittee to look at, and you are codifying some of these cost-sharing activities and see what we can come up with.

Thank you.

Mr. TOWNS. Thank you very much, Mr. Mica. And let me thank all of you for your testimony, but as you depart, let me just sort of make a request.

Ms. Aronovitz, you said something that is sort of sticking with me. When you talk about the managed care, really it is the overservice that we are dealing with now, which is a little easier from a legal standpoint to sort of investigate, because if you take a person's tonsils out, how many times can you take one person's tonsils out. But then when you move to managed care, when it comes to underservice in terms of the quality of care, it becomes more difficult in terms of being able to investigate it and make the case. I do not want you to do it now, but on March 17, this subcommittee will look at the fraud part of the Clinton health care plan. We have jurisdiction over that and of course that would be our first hearing on it. And if you have any thoughts, I would welcome it because we think it is an opportunity to strengthen that health care plan, because if we are not going to look at the waste, fraud and abuse part, we will never be able to deal with the health care problem in this Nation. So whatever thoughts you have on it, I would certainly appreciate you giving it to me.

Ms. ARONOVITZ. I would like to just make one comment, if I could. I appreciate you raising that concern and we will be prepared at the March 17 hearing to address this in detail. Last year our group in GAO produced a major study of the efforts that States

around the country are having going to Medicaid managed care. And I brought five copies of the report with me and I will be happy to leave it with you. It highlights six States that are very aggressive. Florida is really just kind of embarking on a Statewide program now and is in the process of trying to get a Medicaid waiver. So in this report we talk a lot about the lessons learned and also the quality and financial oversight that must be present if you are going to be able to have that type of system.

Mr. TOWNS. Thank you very much, all of you for your testimony. We look forward to working with you in terms of improving our health situation in this Nation. Thank you very much.

Our second panel of witnesses today are Jack Kronfeld, president of the Genesis Health Care; Robert Palenzuela, chief operating officer and general counsel of the Community Medical Plan, Inc.; Marshall Kelley, director of Medicaid, Florida Agency for Health Administration.

And just before you start, let me just say that we have been joined by Congresswoman Carrie Meek from the great State of Florida, who has joined us here. And at this time, I would like to yield to her for any opening statement or comments that she might have. We are delighted to be in the State that she also represents, along with Congressman Mica.

Ms. MEEK. Thank you very much, Mr. Chairman.

This is my city, Miami, where you are conducting the hearing, and I am so pleased that your subcommittee saw fit to come down and to have hearings here. And of course, we are certainly ready to let you know what the problems are here and perhaps even provide solutions to some of them. But we are happy that you came here. I think this is an area of the country where much needs to be done. So I want to congratulate you. You will have the full cooperation of my office and my constituents in whichever direction the committee plans to go.

Mr. TOWNS. Thank you very much. And let me just say to the people of the State of Florida that with Mr. Mica and Ms. Meek, you are in good hands. I think that those of us around the country sort of thank you for that, you know, sending them to Washington.

At this time, we will move forward. Mr. Kelley, let me just say before we start that your entire testimony will be included in the record. So if you just could summarize—as you can see, this is a panel that is full of questions—so if you just would summarize and that will leave us more time to be able to raise questions. So why do you not start, Mr. Kelley.

STATEMENT OF MARSHALL E. KELLEY, DIRECTOR OF MEDICAID, FLORIDA AGENCY FOR HEALTH ADMINISTRATION

Mr. KELLEY. Thank you, Mr. Chairman.

I was asked to speak on Medicaid managed care in relationship——

Mr. MICA. I do not think we can hear you.

Mr. TOWNS. Turn the mike on.

Mr. KELLEY. Thank you, Mr. Chairman.

I was asked to speak on Medicaid managed care in——

Mr. TOWNS. Is that mike on?

Mr. KELLEY [continuing]. Relationship to fraud and abuse——

Mr. TOWNS. Pull it a little closer.

Mr. KELLEY. Is this OK?

Mr. TOWNS. Yes, thank you.

Mr. KELLEY. Florida began its first managed care program in 1983 with the Palm Beach County Health Department. Now, approximately 400,000 of its 1.6 million Medicaid recipients are in a managed care program, about 317,000 in the traditional HMOs and about another 90,000 in a primary care case management system. We have 22 plans operating in 36 of 67 counties, with additional plans pending.

As part of Florida's health care reform, the 1993 legislature called for us to expand managed care Statewide over the next 2 years. Again, this will be a combination of HMOs and a combination of primary care case management system, which leaves then a form of fee-for-service. Managed care is a central part of Florida's waiver request to the department, which we call Florida health security. It is the cornerstone of most American health care reform proposals because it does have a track record in moderating health care costs by reducing unnecessary care and utilization. Most of the commercial population now is in some sort of managed care plan or another. The number of people in the United States that have a strict fee-for-service plan with no restrictions on benefits, utilization or other managed care techniques is a very, very small number at this time.

When you are hearing testimony on Medicaid fraud and abuse, it is important to note that managed care on a capitated basis provides an incentive to control overutilization, overbilling fraud and abuse, without requiring an army of public employees. Florida's managed competition effort will also strengthen what is already built into managed care.

Florida has also developed a number of alternative managed care programs to fit the special needs of the aged, blind and disabled Medicaid recipients similar to the large case management programs used by commercial insurers and HMOs. These Medicaid programs provide a case managed set of home and community-based benefits that are exceptions to the regular Medicaid benefit package, to people who would otherwise require expensive institutional care. Approximately 13,000 Medicaid recipients who are disabled or the frail elderly, 7,000 persons with developmental disabilities and 6,000 persons with AIDS are enrolled in these exceptional benefits programs.

In addition, Florida Medicaid has applied managed care techniques to such case management, prior authorization of services, retrospective review and drug utilization review to the regular Medicaid program. While these are significant additions to the regular Medicaid program, they do not provide the full advantages of a more systematic managed care approach, such as an HMO.

The efficiency gained through managed care programs does not come without certain problems that must be mentioned, but for which we think there are solutions. And these are the problems that you have already mentioned. First, we must put into place standards for quality of care which will apply not only to managed care programs but to traditional forms of health care delivery. Instead of doing too much, we must see that children and other vul-

nerable people do not receive too little. Second, we must work with traditional public providers who have built an infrastructure of programs for the poor to ensure that the move to managed care integrates their services and efforts. We believe that the public health and mental health providers can participate at all levels, including becoming part of private networks and serving directly through our primary care case management programs. The teaching hospitals and specialized services such as the regional prenatal intensive care centers must be included. We plan to look at the true cost of these necessary services and include them as what we call centers for excellence.

Now two follow-ups to the previous panel. First of all, in approving HMOs, we work with the Department of Insurance. We have in the statute that a convicted felon cannot have more than a 5-percent ownership interest or be on the board of an HMO that is approved for Medicaid. We take all people with ownership and board membership and run them by the Department of Insurance to see that they are not currently being investigated or have not been part of a previous plan that has had financial or other difficulties. And with respect to the previous question regarding is it cost efficient to fund the program integrity staff—definitely so. We have a special trust fund we call the grants and donations trust fund that Florida deposits collections from fraud and abuse and third party liability, and it more than funds all of the positions and cost for those services.

Mr. Chairman, in closing, I would like to also make you aware, as has been mentioned before, that we have a fully developed plan called the Florida health security plan—health homes 1994, which we would be happy to provide you for further information.

Thank you.

[The prepared statement of Mr. Kelley follows:]

TESTIMONY
MARSHALL E. KELLEY, DIRECTOR OF MEDICAID
FLORIDA AGENCY FOR HEALTH CARE ADMINISTRATION
MEDICAID MANAGED CARE

FOR

CONGRESS OF THE UNITED STATES
HOUSE OF REPRESENTATIVES
SUBCOMMITTEE ON HUMAN RESOURCES
EDOLPHUS TOWNES, CHAIRMAN

FEBRUARY 25, 1994
MIAMI CITY COMMISSION CHAMBER
3500 PAN AMERICAN DRIVE
MIAMI, FLORIDA

Mr. Chairman, Members of the Committee:

Thank you for the opportunity to discuss Medicaid managed care in Florida.

Medicaid began its first managed care program in Florida in 1983 with the Palm Beach County Health Department. Now, over 317,000 of the 1.6 million are enrolled in prepaid health plans, with another 97,460 people enrolled in a primary care case management system called Medipass. Florida has approved 22 plans operating in 36 of the 67 counties with another 32 plans pending approval. Over the next two years, Florida plans to expand its prepaid health plan and Medipass programs statewide and cover all Medicaid recipients, except for those individuals in institutional care.

The 1993 Florida Legislature requires that "to the maximum extent practical and permitted by federal law, that all Medicaid recipients be enrolled in a managed care program."

Managed care is a central part of the Medicaid Demonstration Waiver application, which we call "Florida Health Security," that has been submitted to the Florida Legislature and the Health Care Finance Administration. In this plan, savings from Medicaid managed care programs and five other sources will be used to provide a basic health benefits package to an additional 1.1 million uninsured Floridians.

Managed care is a cornerstone of most American health reform proposals because it has a track record in moderating health care costs by reducing unnecessary health care utilization. Most of the commercially insured population is now covered in some sort of managed care plan. While the federal Social Security Act, which sets Medicaid program requirements, primarily authorized a fee-

for-service model, it does provide a few managed care options. Florida is already one of the leading states in taking advantage of those Medicaid managed care options.

Unmanaged health care tends to be very expensive health care, especially for the Medicaid population. In the unmanaged fee-for-service Medicaid program, Medicaid recipients may have poor access to primary care and prenatal care. Sometimes access is due to the Medicaid recipients failure to seek care. Other times it is due to recipients not being able to locate a provider willing to provide a "medical home." Too often, Medicaid recipients end up seeking urgent care at relatively expensive hospital emergency rooms rather than from primary care providers. Too often, Medicaid recipients go without care until their condition deteriorates to the point that more expensive specialty and inpatient hospital care is necessary.

Care provided under the regular Medicaid program is sometimes poorly coordinated care. Medicaid recipients are free to change providers whenever they choose. This often means that no one provider has a complete medical record and there is no continuity of care. As a result, one physician may undertake a treatment plan that counteracts the treatment provided by another physician. It also sometimes results in duplication of services. And, some patients end up not receiving preventative and other important services that would reduce the need for additional health services. Thus, this lack of care coordination also has both poor quality and high cost implications.

The regular fee-for-service Medicaid is also limited in its ability to monitor the quality and cost of care. It would take an army of staff to fully monitor the 55,000 Florida Medicaid fee-for-service providers. And, as long as Medicaid recipients can go to any provider willing to treat them, the state cannot place responsibility

for assuring access to care and coordination of care with any particular provider. Yet, poor access to care and poor coordination of care are two of the most important causes of poor quality and unnecessarily expensive care.

While you are hearing testimony on Medicaid fraud and abuse, it is important to note that managed care on a capitated basis provides an incentive to control over utilization, over billing, abuse and fraud without requiring an army of public employees. Florida's Managed Competition efforts will increase the need to eliminate unnecessary or inefficient forms of health care delivery.

Medicaid has developed a number of alternative managed care programs to fit the special needs of aged, blind and disabled Medicaid recipients. Similar to the large case management programs used by commercial insurers and HMOs, these Medicaid programs provide a case managed set of home and community based benefits, that are exceptions to the regular Medicaid benefit package, to people who would otherwise require expensive institutional care. Approximately 13,000 Medicaid recipients who are disabled or the frail elderly, 7,000 persons with developmental disabilities, and 6,000 persons with AIDS are enrolled in these exceptional benefits programs.

In addition, Florida Medicaid has applied managed care techniques, such as case management, prior authorization of services, retrospective review, and drug utilization review, to the regular Medicaid program. While these are significant additions to the regular Medicaid program, they do not provide the full advantages of a more systematic managed care approach, such as an HMO.

The efficiency gained through managed care programs does not come without certain problems that must be mentioned, but for which there are also solutions. First, we must put into place standards for quality of care which will apply not only to managed care programs but also to traditional forms of health care delivery. Instead of doing too much, we must see that children and other vulnerable people do not receive too little. Second, we must work with traditional public providers who have built an infrastructure of programs for the poor to insure that the move to managed care integrates their core of efficient services. We believe that the public health and mental health providers can participate at all levels including becoming a part of private networks and serving directly through our primary care case management programs. The teaching hospitals and specialized services such as the regional prenatal intensive care centers must be included. We plan to look at the true cost of these necessary services and include them as "Centers of Excellence."

In closing, I would like to mention to the committee and the public that Florida's Agency for Health Care Administration has published a comprehensive plan for health care reform--"The Florida Health Security Plan--Healthy Homes 1994." This plan was developed with more than 100 committee, rule and public hearing meetings, including 69 publicly-noticed events. This document as well as others is available from the Agency.

Thank you Mr. Chairman. I will be pleased to address any questions from the Committee.

Mr. TOWNS. Thank you very much for your testimony, Mr. Kelley.

Mr. Kronfeld.

STATEMENT OF YAAKOV "JACK" KRONFELD, PRESIDENT, GENESIS HEALTH CARE

Mr. KRONFELD. Thank you, Mr. Chairman.

I must tell you after listening to the first panel, as someone who represents more than 500 providers in central Florida, one would normally feel a little bit discomfort. Obviously no provider likes to hear, and I must assure you of this, of instances that are so widespread of fraud and abuse. Again, I must emphasize that it is only in the providers' best interest and certainly the managed care providers, that in fact to the degree possible, that we eradicate fraud and overutilization and abuse, and that is certainly a common goal that we have.

As Mr. Morris said, however, from the first panel, though we might have aspirations to change human nature, we are not very likely to do that, meaning that unfortunately we have in society people who are determined to commit fraud. The reality is we need to have systems that in fact make the commission of fraud rather uninviting.

Unfortunately, the Medicaid system as structured currently unfortunately invites, to some degree, fraud. And let us look at some of the basic components.

If we look at a number of States, and I will be happy to talk about Florida and the State of New York, to some degree we have ceded the Medicaid program to the nonmainstream physician. For example, if I may give an example from New York State, if we were to take any of the five boroughs or Orange, Rockland Counties in New York, we would find that the participation in Medicaid is very small as a percentage of those physicians—and I emphasize physicians.

We have the problem also in Florida, though to a lesser degree because the Medicaid fee schedule is somewhat higher, meaning that to a great degree we have emphasized the provision of Medicaid services by those in fact who may look at fraud as the ability to justify their participation.

As an example, and one that would hopefully point out the problem, in the State of New York, for example, the reimbursement for obstetric care is about 26 percent of the going rate of the commercial rate. Obviously many providers have made a decision not to participate in Medicaid, and as I indicate in my testimony, unfortunately one, because of the monetary aspect; two, because of the issue of being able to determine eligibility, which of course in Medicaid changes quite frequently; and three, unfortunately because of opinions which are unfortunate but which are held by many physicians in terms of conduct of their offices, many private physicians have elected not to participate in the Medicaid program. So by nature, we are left with some providers who look at fraud as their only means of securing not only a good income, but a very large income—and it is unfortunate.

As a Medicaid managed care provider, however, we feel we are able to overcome some of these difficulties and interest the main-

line physician in participation one, because of economic reasons; two, elimination of hassle; and three, of making the Medicaid patient load part and parcel of a normal practice of medicine, which we think is important.

Obviously I was impressed by the members of the panel who met before us. I must tell you, however, with all of the good inclinations and efforts on their behalf, I am rather skeptical that investigative efforts alone, no matter how much they are implemented, no matter how much we are able to abet their efforts through increased funding, that in fact will make a large dent on Medicaid fraud. I think if a system is blemished such that we reimburse on a procedure basis, we are going to get exactly what we ask for—more procedures, and we have succeeded in doing that, unfortunately to the detriment of the budgets of every State.

I think that managed care, with all of the issues that I think were correctly brought up by the previous panel, it at least provides a methodology that the State is able to budget and to get as a quid pro quo that which they have asked for, and that is a global package of services provided on a quality basis. And I think that that is a methodology and I must compliment both the States of New York and Florida, that has now been pursued rather aggressively. And again, certainly managed care is not a panacea and I certainly would not present it as such. But I think that in terms of getting the most for the taxpayer's dollar, that will be much easier to oversee and to manage the quality of care and the type of care that is provided in a much smaller number of institutions and organizations. And I think that that will, hopefully, provide to Congress and to the taxpayers better benefits to our Medicaid beneficiaries. We certainly pay enough to ask for that.

Thank you.

[The prepared statement of Mr. Kronfeld follows:]

COMMITTEE ON GOVERNMENT OPERATIONS
SUBCOMMITTEE ON HUMAN RESOURCES AND INTERGOVERNMENTAL RELATIONS
HEARING ON "MEDICAID FRAUD" - FEBRUARY 25,1994
MIAMI, FLORIDA

TESTIMONY OF YAAKOV (JACK) KRONFELD

The Basis of Medicaid Fraud and Abuse

It should come as no surprise to most observers that the Medicaid program may be rife with fraud and abuse. The program includes several elements which by their very nature likely serve as a breeding ground for these disturbing phenomena. These may be summarized as follows:

a) "MONEY" - Medicaid reimbursement rates for procedures performed by physicians are generally well below community norms. Often Medicaid payment levels are only a small fraction of usual and customary charges.

b) "HASSLE" - Despite some recent improvement in Medicaid database access, provider payment is still plagued by the difficulty of verifying current eligibility and rejection of seemingly valid claims. Unlike Medicare, the Medicaid program is marked by changing eligibility which requires "real-time" verification of eligibility.

c) "UNDESIRABILITY" - Many physicians, unfortunately, prefer not to treat the Medicaid patient as part of their practice. Some offices may consider the presence of typical AFDC beneficiaries in the waiting room (e.g. a young mother with three or four small children uncontrollably roaming the waiting room) undesirable in terms of attracting other "paying" patients. The Medicaid patient is often faulted for missing or being late for appointments and being non-compliant in following physician orders or taking prescriptions. The common perception is that the Medicaid beneficiary may lose eligibility thus "saddling" the physician with a non-paying patient whom they cannot abandon.

Given these factors, the relatively low participation of physicians in the Medicaid program, while perhaps not admirable, cannot be considered unexpected. Even those physicians who participate, often have offices that are relatively inaccessible to the Medicaid populace. Poor neighborhoods seldom are served by an adequate supply of community physicians.

Since the normative medical system that services 75% of the population is largely unavailable to the Medicaid populace, four non-normative health system components have filled part of this void. They are: a) the prototypical Medicaid "mill"; b) the Federally-Qualified Health Center ("FQHC"); c) the Public Health Unit and, d) the center-city hospital. All four have contributed considerably to the burgeoning expenses of the Medicaid program.

Medicaid "Mills"

Despite the low payments rates proffered by M e d i c a i d , a financially lucrative practice can be based on Medicaid. Unfortunately there is a clear temptation to "game" the system for maximum reward. Phantom visits, medical procedures or prescriptions are unlikely to be challenged by patients who have no out-of-pocket charge. Unnecessary referrals to "captive" diagnostic or specialty providers are difficult to detect.

Federally-Qualified Health Center ("FQHC")

The FQHCs have undoubtedly performed an important role in bringing primary care to underserved areas. Unfortunately the manner in which they are compensated for the Medicaid services that they provide acts as a clear catalyst to higher overall Medicaid expenditures. FQHCs are reimbursed on an FQHC-specific per-visit basis (I've encountered per-visit payments that fall largely in the $65-$80 range). These amounts are in excess of comparable Medicaid fee-for-service levels. It must be emphasized that this seeming over-payment frequently acts as an essential subsidization of non-reimbursable care provided by the FQHC.

Public Health Units ("PHU")

PHUs are a critical element in combatting medical risks to the public. They play a key role in limiting the transmission of childhood diseases through their immunization programs and the spread of sexually-transmitted diseases through their contact programs.

By and large, however, the PHUs cannot adequately assume the role of primary care giver to the Medicaid populace. PHUs, by their nature, often do not enjoy professional staff stability. Their physician staffs generally do not take after-hour call nor work on weekends. Quality primary care requires a stable physician-patient relationship and a 24 hour/day commitment. PHUs generally cannot meet this need.

Center-city Hospitals

Inner-urban hospitals have played an important role in providing access to medical care for the Medicaid populace. Most central urban areas lack a sufficient physician presence to service local neighborhoods. Such hospitals have become the locus for most care, as even primary care is regularly provided in the emergency room.

This relatively unfettered access to the hospital emergency room has come with a huge cost. Emergency room utilization for Medicaid is often 6-8 times more frequent than a comparable commercial age group. The easy entry into the emergency room has also contributed to a hospitalization rate several times in excess of similarly aged non-Medicaid people. The present Medicaid system has succeeded in exchanging $45-$50 physician visits for $300 emergency room bills (or even $3000 hospital stays).

In some locales, the center-city hospital has established out-patient clinics to deal with the indigent population that frequents the emergency room. These are certainly an improvement over the chaotic nature of triaging that denotes most emergency rooms. These clinics, however, are frequently troubled by lack of professional continuity. After-hour care is generally provided by the emergency room whose contact with the clinic's physicians may be minimal.

Limiting Medicaid Fraud and Abuse

In relative terms Medicaid abuse and waste probably outweigh Medicaid fraud by a factor of two or three to one. Both constitute, however, a problem of sizeable magnitude. In order to combat these problems my suggestions are:

1. Government should get out of the medical indemnity business. Medicaid costs, even measured on a per beneficiary basis, have increased at a higher rate than those associated with private insurers. This has occurred even though governments have largely been able to freeze provider procedure payment rates. Private insurers do not have this luxury.

   The proper role of the government is to determine Medicaid eligibility and to make global payments to providers who manage the care of these beneficiaries.

   With all respect to the investigative services of the various state and federal agencies, they will never be able to seriously curtail the levels of fraud and waste found in Medicaid under its current system. When you pay for procedures that is what you will generate. The attempts to restrict program cost growth through procedure cost freezes has largely failed.

2. The Medicaid system should be changed from a procedure-based reimbursement system to a system of monthly global per capita payments to provider companies capable of providing comprehensive benefits to beneficiaries. The procedure-based model has proven itself to be costly, prone to fraud and ill-designed to insure primary care.

   Such a change does not, by itself, insure an end to fraud and waste. It does, however, substitute a defined per capita cost level for the wasteful and open-ended procedure reimbursement system. The global provider of care can then coordinate quality care within the confines of its predetermined budget.

Mr. TOWNS. Thank you very much, Mr. Kronfeld.
Mr. Palenzuela.

STATEMENT OF ROBERT PALENZUELA, CHIEF OPERATING OFFICER AND GENERAL COUNSEL, COMMUNITY MEDICAL PLAN, INC., HALLANDALE, FL

Mr. PALENZUELA. Thank you, good morning.

In summarizing my testimony, I would like to say that rather than throwing a great deal of funds into investigative efforts such as my colleagues here have said, I think we have to look at the programs that exist to provide Medicaid services and expand on those programs.

Medicaid managed care was implemented in the State of Florida in 1981 and since then has saved the State well over $100 million, since its implementation. Going forward, Medicaid managed care is taking a much more aggressive and high-profile efforts in the State and I believe that these efforts will increase the savings dramatically in the years to come.

Managed care itself is not the solution, but it is certainly an effective way of maintaining fraud and abuse at a low and controllable level.

There are certain aspects of managed care that we would like to see changed, which would certainly improve the system dramatically. One of those things is that right now it is a private/public sector, it is a voluntary program and there is a great deal of competition among the plans that are competing in the State for these members. This competition, primarily seen in the marketing efforts of these plans, leads to—again, I am not going to say fraud and abuse, but certainly some misrepresentations on the benefits of these plans to these individuals. I think that there is too much pressure put on these plans and on these marketing representatives to bring in members, because it is a voluntary program, that certain paths are not taken that would lead to the effective running of the plans.

I think that if there was a lock-in of membership of Medicaid recipients into the plan, then you would see a decrease in the marketing efforts, decrease in the amount of capitation needed for these plans to cover their marketing costs. Rather than the money being spent on marketing and soliciting these members, we could spend that money on care and expanding the additional benefits that are given to these members.

Another problem that we have is that a large number of these Medicaid recipients lose eligibility on a month-to-month basis. We have members that enroll in 1 month and the following month lose eligibility and there is a loss of continuity of care. I know that Ms. Aronovitz in the previous panel mentioned quality of care being an issue with managed care plans. I think that is not an issue if you can lock in the Medicaid members into your plan for a minimum of 1 year at a time and this member can now establish a relationship with his physician, their primary care physician. This will lead to a continuity of care, you have a physician that is aware of the patient's needs on an ongoing basis, has the resources to see this physician at their discretion and I think it leads to better health care and certainly a decrease in the amount of

overutilization because the patient now realizes that there is no barricade to them receiving the care they need from their primary care physician. So I think I would like to stress the fact of a lock-in of Medicaid membership rather than a month-to-month would certainly benefit the program.

I noticed they mentioned that in New York they went to an ID card with a picture. I think that is a very good plan if you are going to lock the member in for a 1-year period on Medicaid. If they are going to lose eligibility on a month-to-month basis, you are going to have to recreate these cards almost monthly, and I think that will add a cost to the program that is unnecessary.

Thank you.

[The prepared statement of Mr. Palenzuela follows:]

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Managed Care Solutions To Medicaid Fraud and Abuse

**Testimony to the House Committee on Government Operations,
Subcommittee on Human Resources
and Intragovernmental Relations**

**Presented by Roberto Palenzuela, C.O.O. and General Counsel
Community Medical Plan, Inc. of Hallandale, Florida**

While the causes of Medicaid fraud and abuse are many, I am pleased to be here today to focus on some proven solutions and offer some suggestions for the future of the reform process.

Leadership in both parties is paying a great deal of attention to the potential benefit of introducing private sector accountability, controls and incentives to government programs in order to enhance their quality and efficiency. Florida's cutting edge Medicaid managed care reform program, in which my company is a participant, offers clear evidence that there is merit to that approach.

Since 1981, the State of Florida has authorized private companies to offer a full-service managed care option to Medicaid recipients, mostly women and children. Success of Florida's Medicaid Managed Care Program has been good. In the last 12 years, these private/public partnerships have saved the state well over $100 million in Medicaid spending.

Under this program, the potential for fraud and abuse is virtually eliminated. The plans are paid a flat monthly fee for each of their members, accept total risk and are required to offer the most comprehensive range of services that has ever been available to Medicaid recipients. The members have unlimited access to their primary care physician and every possible specialty service is available, when needed. Actual treatment is supplemented by health education, pre-natal care, preventive dentistry and other tools that are intended to keep our members healthy and utilize better health care as a key to a better way of life.

Managed Care Solutions to Medicaid Fraud & Abuse
Testimony by Roberto Palenzuela

Because we are paid a fixed fee for each plan member, the potential for the plans to defraud the state is clearly eliminated. The potential remains for physicians to defraud the plans by ordering unnecessary tests, medications and treatments; however, the managed care organization's utilization and review procedures are designed to detect and prevent this. By contrast, it is very difficult for state agencies to police the hundreds of Medicaid providers who submit fee-for-service bills.

Florida is to be applauded for leading the nation in offering a managed care option. The Florida plan has been a model for managed care proposals by other states, as well as the federal government. However, in Florida there is another kind of waste and abuse that has resulted from the voluntary nature of the program and the many other options that are available to Medicaid recipients. Currently, in addition to the option of joining a managed care plan, those eligible can receive traditional care on a fee-for-service basis. (This is the most expensive option for the taxpayers and most greatly limits services available to the patient.) The most recent option is the state's own Medipass program which is intended to increase access to family physicians.

Because there are so many options, and because members of a managed care plan are allowed to change plans monthly -- with virtually no restrictions -- the opportunity for managed care to be recognized as a comprehensive solution is hurt. For one thing, competition among the plans for members is very heated. Because disenrollments are unrestricted, marketing efforts to sign up new members are vigorous. People signing up for plans continually complain that they were misled by company representatives. Sometimes this is true and other times Medicaid recipients do not want to accept personal responsibility for their independent decision to join a managed care plan. We believe that for Medicaid managed care plans to be truly effective as a solution to fraud and abuse of the system, those enrolled in managed care must be required to remain in the program for a minimum of six months. Needless to say, fail-safe grievance procedures and government oversight will insure the quality of care.

We also believe that an equitable system of allocating eligible Medicaid recipients to approved plans would eliminate the potential for misrepresentation that does exist in a high-pressure direct sales environment. Our company is very conscientious in its marketing. However, whenever private companies can be portrayed in the news media as selling entitlements, a serious disservice is done to our sincere efforts to provide better health care as part of a public/private partnership.

Other states, that have learned from Florida's model, have addressed some of these problems. In Tennessee's TennCare program, members are required to stay with a plan for a minimum of one year. This assures that patients will build relationships with their physicians and receive the continuity of care that is crucial to living healthy lives.

Under managed care, Medicaid recipients -- usually for the first time in their lives -- have their own family doctor, who they can get to know, and who can get to know them. As many of us know, the relationship between a patient and the family doctor often goes beyond treatment of illness. When our members get to know their doctors, they find concerned individuals who are eager to counsel mothers and children on nutrition, safety and other issues that are key to ending the cycle of welfare and dependence.

On the other hand, the current system requires Medicaid recipients to seek out clinics, public health units and hospital emergency rooms. In these settings, those providing treatment don't have personal relationships with their patients and may be processing hundreds of line-item Medicaid claims weekly. Patients sometimes must wait weeks to see a doctor and often don't seek care until symptoms are acute.

Managed care may not be the choice of every American. However, I am convinced that the only way to eliminate fraud and abuse in the Medicaid system, and assist recipients in accepting personal responsibility for their health care, is to require that Medicaid recipients be part of a managed care plan. This will also be an important part of a more complete reform of the welfare system.

Mr. TOWNS. Thank you very much. Let me thank all three of you for your testimony. I have a couple of questions really.

One of you, I think it was you, Mr. Kelley, said that as a result of moving to managed care, that you felt that this would curtail the fraud and abuse—or was that you, Mr. Kronfeld? Mr. Kelley, I think it was you.

Mr. KELLEY. It curtails—the incentive is certainly not to overutilize and overbill. The opposite problem that can take place is a problem, and that is where people are underserved.

Mr. TOWNS. What happened to the other part of it though? I think that the fraud sort of shifts and it becomes even more difficult to detect. I think in one plan, you are talking about, in terms of overbilling, and then when you go to managed care, I think the concern would be under.

Mr. KELLEY. That is correct.

Mr. TOWNS. And I think that could be a problem as well to, because you are talking about cutting costs and saving costs, and I think that would be even more difficult to detect. And I think that you might even need more people involved to be able to analyze that. As I gave the example early on, if a person comes in and they have had their tonsils taken out four times, you know there is something wrong. I think that is clear, that is something you can move forward and investigate. But the fact is that if something needs to be done and it is not being done and you are being paid, that becomes another problem.

So what I am saying to you is that I still think that in managed care there still can be fraud and abuse, but I think that it just is done another way.

Mr. KELLEY. Well I think you are correct, and I think we have two things that we are looking at to judge that. One is—and the Florida Legislature is meeting now and both the House and Senate health care committees have just passed out bills that put into law for HMOs and managed care programs specific standards for children, which is what has come down from the Federal Medicaid program in the past known as EPSDT, early periodic screening diagnosis and treatment, program for children, which ensures that all children get adequate number of visits to the physician and so forth. Now the HMO cannot, for example, make the mother bring the child in. But we can require them to send several notices for each visit to the family, to say the visit is due, that the child is due for an exam and so forth. And we can see that the managed care provider has done that, and go out and look and see that they have done that, for example.

So that is one example of yes, as you move to managed care, there will have to be additional standards and you will have to look at additional things to make sure that vulnerable people are getting the service that they need. And the other side of the thing of course is a strong grievance procedure for the individuals themselves to say I am not getting a service and what are you going to do about it. I mean, that is the second part, but obviously children and other vulnerable groups would not necessarily know that they are not getting what they are supposed to be getting. So we have to be very active in looking at and setting standards and looking to see that they meet them.

Mr. PALENZUELA. Mr. Chairman, if I may, let me clarify something for you. The plans themselves do not determine the care that is received by the members. They are received by their individual physicians, who determine what kind of care and what the course of care is for these members. The plans do not impose their own views of how medicine should be practiced. It is very important that we make that distinction. All we do is we, in consultation with physicians, determine whether additional types of specialty type of care or hospitalization is necessary or if there are alternatives that are available on an outpatient basis or at the primary care physician's office that are more cost effective. But we do not make any efforts to practice medicine or tell physicians how best to practice medicine.

Mr. TOWNS. I understand that, but I think we are also talking about cost, we are talking about cutting costs and we are talking about saving costs, and that is what the issue is. So where you have overbilling in one situation and then where you are cutting and trying to save costs, because then that is the way you make money on this end. So that is a real problem and I think that we cannot overlook that.

Mr. PALENZUELA. Oh, I am not saying we should overlook it at all. I am sure there are some plans that are guilty of that, but I think you have to realize that a lot of these plans spend a great deal of money on quality assurance type programs and meet what are considered national standard of quality of care and are constantly monitoring the physicians and researching and making sure that the physicians themselves are not guilty of underutilization, because the plans themselves are most interested in making sure that the patient receives not overutilization and certainly not underutilization, but that which is appropriate and medically necessary.

Mr. TOWNS. I agree.

Let me just sort of move along then. Mr. Kelley, I am struck by your statement that we must work to improve on infrastructure programs for the poor if we are to create a useful managed care system. I am concerned that public health departments are being dismantled in every city in this country, including teaching hospitals. I do not see a serious commitment to this public health infrastructure in any of the proposals now being debated. How can we create the centers of excellence you discussed in your statement and how much will it cost, because the New York teaching hospitals may be put in jeopardy, you know, as a result of this.

Mr. KELLEY. Well that is a good question. Now first of all, my concern is how we continue and bring the necessary parts of all of those things that you mentioned into health care reform and a new system. We have had a great number of meetings with all of those individuals as we proceed in Florida.

With the centers for excellence and the teaching hospitals, the effort there is to actually define the cost of that. For example, a teaching hospital may be doing primary care, but it is doing all those tertiary care, the real sophisticated things. We need to identify those and the teaching aspects of that and fund those straight up.

On the primary care type of things, they may have to compete in that area with other managed care and with other types of programs. It is the same way with our public health, there is a core of public health that certainly will always need to be there—epidemiology and all the kinds of other things public health do. When public health expands into primary care, then that part of the public health system needs to participate through networks of managed care programs through our primary care case management system, Medipass we call it in Florida, and we have found a way, for example, that they can do that, that they can be participants as primary care physicians as well.

But when you look at these structures, a part of them has a unique infrastructure type of thing that needs to be continued and funded straight up, not just funded through fees from Medicare/Medicaid, and a part of it is going to have to compete with other groups.

Mr. TOWNS. Thank you very much. I see my time has expired, I now yield to Congressman Schiff, and then if I am not back—I am going to step out for a moment—then at that point we will yield to Congressman Mica and then yield to Congresswoman Meek, if I am not back.

Mr. SCHIFF. Thank you, Mr. Chairman.

I just have a couple of things to ask. Mr. Palenzuela, does the company you represent have managed care only for Medicaid recipients or is that part of a broader managed care program for all people that you might accept?

Mr. PALENZUELA. Presently we are a Medicaid-only plan, our emphasis is on the indigent care, it is where all our executives' background is in indigent care.

Mr. SCHIFF. And how long—may I ask—let me tell you what I am getting at here and I do not mean to have surprises here. But it is mentioned throughout the testimony that a factor that is here—and of course it is a factor in other ways, is the low rate of Medicaid reimbursement compared with the going rate for a particular service on what we might call the open market. In fact, when the President of the United States talks about the effect of the uninsured at work cost-shifting the system, the President is right, cost-shifting in the economic system is not the uninsured through employment, it is the Federal Government because of its low reimbursement for Medicare/Medicaid, in my judgment, that is pushing cost-shifting, so I guess I am surprised to hear that there is a company which believes that it can be economically successful because you are in that business too, solely on Medicaid, and that is what I am pursuing here.

The company you are referring to, I mean, did it begin solely on the whole idea of indigent care or is this a subsidiary of an existing managed care program?

Mr. PALENZUELA. It started solely with the focus on indigent care.

Mr. SCHIFF. OK, and how long ago—I am sorry if you said, I do not remember—how long ago did your company get into this business?

Mr. PALENZUELA. About 2½ years ago.

Mr. SCHIFF. And at least at the moment, they feel that they are able to function economically under the—I assume they have a contract like Medicare providers do on HMOs and that is a flat fee for each indigent——

Mr. PALENZUELA. Yes, we get a capitated, which is a monthly fee from the State of Florida, for every member, a flat rate based on that particular county's going rate for fee-for-service, we get paid 95 percent of that. So the State already off the top takes 5 percent.

Mr. SCHIFF. That is how Medicare operates.

Mr. PALENZUELA. Right. What you have to understand is that traditionally your Medicaid recipient has received care not through physicians but through emergency rooms at hospitals, which is the most expensive form of care, which is why we believe that by using primary care physicians for these recipients, giving them a personal, private doctor that is on call 7 days a week, 24 hours a day, that we can reduce costs.

Mr. SCHIFF. Oh, I do not dispute the point. I am just—from what I hear about the rate of Medicaid reimbursement, I know physicians back in Albuquerque where I come from, who either do not take Medicaid patients, or I know physicians who take them and do not bother to bill the system because by the time you go all through the paperwork, your reimbursement is so low, they just do it as a pro bono, you know, community service as part of their professionalism.

I guess I am struck from your company's point of view, that you apparently are able to provide what you believe is a high quality of service and still make an economic profit at the end of it.

Mr. PALENZUELA. Oh absolutely.

Mr. SCHIFF. Or you would not be doing this.

Mr. PALENZUELA. And maybe I may infuriate some people, but I think if you locked in the members and I did not have to spend money on marketing, you could actually pay me less and I could still be profitable.

Mr. SCHIFF. Well I cannot resist asking what I think the chairman was getting at, and that is, managed care is increasing in this country rapidly. In fact, Albuquerque, perhaps of all places, is one of the most penetrated markets in the Nation. We had over 50 percent participation when other countries did not know—pardon me, I meant to say other States—did not know what the letters HMO stood for.

I cannot resist asking then, would one be able to tell the difference in HMO care generally between what your company provides to Medicaid recipients and what someone could go sign up for through their middle class employment?

Mr. PALENZUELA. Absolutely not. We are mandated to provide the exact same care anybody else would. In fact, we require our primary care physicians, and we are constantly monitoring them to make sure that they are at a high level of care.

Mr. SCHIFF. Mr. Kelley, did you want to answer?

Mr. KELLEY. Yes, I think I can contribute one thing to that. While the physician fees, at least according to all our physicians, is quite low and what you are saying is correct there, the hospital in-patient costs are really on a cost reimbursement system so that

hospitals and other institutions get paid quite a substantial fee that is not below any market price.

Mr. SCHIFF. This is the primary care——

Mr. KELLEY. Right, so that when an HMO is able to cut down the hospital in-patient, that is where really all the money is saved, it is not saved—as a matter of fact, when you move into primary care, sometimes the office visits and the prescriptions both go up because you are getting people earlier, treating them in the office and with medication instead of—in some cases Medicaid recipients have not been able to find adequate providers, wait until they are sick, go to the emergency room, then have to be admitted and that is really the high cost.

Mr. SCHIFF. Well let me say I am not—I think there is an issue over managed care, I think the chairman has raised it. There are issues that you can get into in what is encouraged in fee-for-service, there are also issues of what you can get into with capitation costs and the encouragement to live within that budget. Those are general issues.

I am trying to figure out the economics here and if I understand them correctly, hospitalization is a separate matter for your patients then, Mr. Palenzuela, do I understand that, that the capitation fee does not include——

Mr. PALENZUELA. Yes, it does. We cover all care, we are totally at risk for all care, including hospitalization.

Mr. SCHIFF. So from the monthly fee, you also pay the hospitalization cost if your patient is hospitalized.

Mr. PALENZUELA. Yes, we do. We contract with hospitals at a reduced, what we call per diem rates, which is what we would pay for a 24 hour stay in a hospital. What we do is we research whether there are other options for care that do not require in-patient hospitalization.

Mr. SCHIFF. Well I just have to say that is a—and like I say, I am leaving aside the larger philosophical questions about managed care versus fee-for-service. I just have to say that presuming the quality of care is at least reasonable—and I mean no detriment in phrasing it that way—I have to say that is a remarkable accomplishment, given that I know health care providers back in Albuquerque who will not treat Medicaid recipients because the economic reimbursement is so low.

Before I yield to our colleague, Congresswoman Meek, Mr. Kronfeld, did you wish to add anything to what I have raised with your panel?

Mr. KRONFELD. Well just briefly a clarification. Obviously I am in much the same situation as Mr. Palenzuela. In terms of the physicians, we are, as a private entity, able to pay our physicians competitive rates to interest them to participate. The fact is a large number of our physicians do not normally participate in Medicaid, or at least not on a large basis.

Mr. SCHIFF. Exactly.

Mr. KRONFELD. But because we can provide them with additional dollars to make it unlike the circumstance which you might face in Albuquerque, suddenly we have opened up Medicaid again to the mainstream of physicians who otherwise frankly have chosen not to participate. And with that, again, the quality of the care is first

and foremost dependent upon the quality of the physicians that participate.

Mr. SCHIFF. Well it just sounds to me like a remarkable accomplishment to have been able to organize that in the face of the fact that so many health care providers find the economics counter-productive in their particular case.

In the chairman's absence, I am going to take the liberty of yielding directly to our colleague from Florida, Congresswoman Meek.

Ms. MEEK. Thank you very much, Mr. Chairman.

I was very much interested in Mr. Kronfeld's testimony in that I heard in his testimony some real live problems with the Medicaid program. My experience with Medicaid over the years has been that many of the, what you would call, top level doctors, did not want to serve this constituency. These clients were not served by the top level doctors. And it is not until now that it appears, through health care reform, that there will be more attention paid to the poor patients. You are going to find now all of a sudden these poor patients or clients that these doctors did not want, they will begin to perhaps be very competitive in terms of getting them. I have seen this happen over the years, I have seen the emphasis on marketing, which you mentioned, and it is to the point that many times they go out in these real poor communities, particularly inner city communities, and do the kind of subscription which you are talking about. And I agree with you, there is too much emphasis on that, there should be much more emphasis on care.

And also, there is a two-tiered level of care here. One for the rich and one for the poor, and hopefully—I do not know how you are going to resolve it, whether it is managed care or whatever, but this committee, I am thankful that they came down to hear some of the problems all over this country with Medicaid fraud. And many times it is brought about because the government made it too easy, they made it too easy, they made the care of these patients, they put it on a lower level and because of it now, the problem is they are using the system to bring about this fraud and abuse. I do not say that it should not be punished, I think it should, but I agree with you, investigation will not solve it. It will help, but the delivery system has to be changed in order to bring about the level of care for everyone that they deserve.

That is why I rushed to get down here this morning. I really wanted to hear some of the testimony and to thank the subcommittee for coming down—Mr. Schiff and my colleague from Florida for coming down, they have very strong interest in this, and we thank you so much.

Mr. SCHIFF. Again in the chairman's absence, I would yield to my other colleague from Florida, Congressman Mica.

Mr. MICA. Thank you, Mr. Schiff.

Mr. SCHIFF. We are going to make you the Republican leader.

Mr. MICA. I appreciate it, I will just take my lowly position on the committee and be happy to function in that capacity. It is good to see Representative Meek here too. We served years ago together in the legislature. I was leaving and she was coming and she does a great job representing south Florida, and Florida, and I appreciate her coming out today. There are no votes today and people could be with their families or their constituents and I particularly

appreciate that. Mr. Schiff is on his way back to Albuquerque, NM, people do not realize the sacrifice they make sometimes in participating in these hearings when they could be doing other things.

But our mission is important, as I said, and this panel was of particular interest to me for several reasons, because Florida is going from the government oriented Medicaid approach to a managed care approach in a fairly significant fashion. Is it about 20 percent now are in this type of a program, managed care program?

Mr. KELLEY. About 25 percent of the Medicaid population.

Mr. MICA. OK. And what do you see as the transition time, how long before—and do you see the whole thing being converted eventually to managed care?

Mr. KELLEY. I see 2 years, which is what is a part of our legislation, but there is one important thing to understand about that, that means that everyone will be in managed care, but about a third of the people will be like in HMO prepaid capitated plans and about two-thirds of the people will be in a primary care case management where they have a primary care gatekeeper, but the services are still reimbursed on a fee-for-service basis.

Mr. MICA. What is the cost differential with the experience you have to date with 300,000 plus people in the managed care area versus the straight Medicaid program?

Mr. KELLEY. Over the 2 years—and we have differences between major consultants like Arthur Andersen who have looked at it, the Urban Institute and the Agencies on Policies, but the low is 5 and the high is about 10 to 12, savings——

Mr. MICA. Are you talking percentages or what?

Mr. KELLEY. Yes, percentage.

Mr. MICA. So it is more cost effective to go to the managed care, according to different——

Mr. KELLEY. Yes, it is, it is in that range of, you know, 5 to 12 percent.

Mr. MICA. What about your experience so far in the—are there 20 some independent providers now? What about monitoring them, and Mr. Kronfeld mentioned that, you know, the investigative approach is important—I mean he actually did not think it was that important, we needed to look at changing as rapidly as we could from the pure government approach, the reimbursement approach for services, to the managed care approach. What is the situation with this?

Mr. KELLEY. OK, well certainly as I said when I was making that other distinction about two-thirds being in primary care case management with fee-for-service, we certainly will need a strong investigative—we will certainly need to continue the utilization and program integrity and fraud and abuse investigative type activities like we have done. The only difference is that it swings the incentives toward doing the right thing, which we do not have now. For example, in the previous question about, you know, why would they take low physician fees, the incentive there is to treat a person in the office with medication instead of letting them get sick and have to go into the hospital where it is much more costly. They make money if they do that successfully, we save money if we do that successfully. And the only problem is we have to make sure that

vulnerable groups, children and so forth, get the number of services that they need. And we will still have to look at that.

Mr. MICA. As we make this transition from one system of providing services to another, are the resources—are there adequate resources being paid—attention being paid to now overseeing the new managed approach?

Mr. KELLEY. That is an excellent question, and what has happened is over the past year, these kinds of problems, like we have talked about, marketing and so forth, have surfaced to a stronger extent each and every month, and I think that we are in the process right now with the Florida Legislature of strengthening what we have in statute with respect to our ability to regulate the kind of problems that have been developing with respect to marketing and other types of activities where that has come up.

Mr. MICA. And Ms. Meek brings up a good question, the qualitative care versus the quantitative approach of signing these folks up and then making a determination. You do not want to create instances where there is a different type of abuse of the system by signing people up for less than say a certain standard or quality of care and shifting them into this new system. So is there anything in place to regulate the activities of these new groups, that takes that into consideration?

Mr. KELLEY. At the current time, a Medicaid recipient is not locked in, so if they sign up with one provider, HMO, et cetera, and they are not happy, they can change, disenroll and change that next month.

Mr. MICA. So it is left up to the consumer.

Mr. KELLEY. Left up to the consumer, but as part of Florida's proposal, we will be asking for a lock-in period for a year, but with an up front 45 to 60 day period where they can change their mind and then make the decision.

But what we have proposed, the agency, the Governor, to the legislature is what we call a choice counseling program, which lets the Medicaid recipient know, in your area there are, for example, three HMOs and the Medipass program. You are going to be locked in for a year and you need to give careful thought to what the benefits are for each program and make a choice, and we are asking for the resources to try to help them make an informed choice so that they do not get into something and, you know, feel like they are stuck in something that is a decrease in terms of their level of care.

Mr. MICA. Well from the Federal level now, again, you are changing to managed care, and from the Federal level, you are still going to have bucks flowing—a tremendous number of bucks flowing through the system, being given to different providers here. How do we ensure, and what mechanism can we put in place, to make sure that we are getting, you know, the bang for the buck and that people—we are not providing cash cows to providers and they are not providing a level of quality care—again in line with the questions Ms. Meek presented.

Mr. KELLEY. I think you are going to end up doing what you have done in the regular Medicaid program that I was referring to, like the EPSDT. You have got standards now for all the States in terms of how—that they need to see children, that they need to do all of these things in evaluating the child's health, and the States

must do this. We are transforming that into a similar type of thing for the HMOs under Medicare and other health care reform. The standards may be a little bit different because of the structure, but the standards may still need to be there.

So you will still need to have standards as you move to managed care, No. 1. And No. 2, as part of the whole health care reform, there is an emphasis on developing what is called outcome measures, and that is—you know, I do not like to talk too much about that because it seems like too much in the future, but that ultimately is what we both need to determine what we are getting for our dollar, not only where it went and whether it was overbilled, but have we improved infant mortality, have we done all of these specific things that we are directing our resources at.

Mr. MICA. Now you know, you two are at the other end of the spectrum and I might like you to respond as to what you would see of the Federal role, you know, in a participatory fashion, that would allow you to do what you need to do but allow us to provide some oversight to the process. I would welcome your comments there.

Mr. KRONFELD. Well first, I think that Mr. Kelley has spoken modestly. The reality is that his department has done a yeoman's job with frankly very little staff, and I think that now in the State of Florida, we have nearly 400,000 people in managed care on the Medicaid side, that we have to have the resources. I must tell you—I will speak for Genesis certainly—we do not oppose oversight. In fact, we would prefer that there is strong oversight so that we know the sort of quality that is perceived by outside objective observers.

Talking about the Federal role, I must tell you that it is difficult for a plan that interfaces only with the State to determine what the right and proper role of the Federal Government is. I think that the States certainly have had burdens in the last few years in terms of the increase of eligibility that has added to the fiscal cost to the States, but again, I think that is an interplay between the Congress and the State, and not really in the perspective of the individual plans.

We think that given the size of the State of Florida and the ability of the State to oversee the 11 or 12 million people in the State in terms of the provision of the care, I am not sure that effective oversight need be at the Federal level. I think that the State needs the sort of waivers that are important, that it in fact can look for innovative manners much closer, so to speak, to the action, to provide oversight. And again, I think it is a very difficult at a Federal level other than providing flexibility to the States, to have a cookie cutter approach to how we are going to oversee managed care throughout the 50 States.

Mr. MICA. Mr. Palenzuela.

Mr. PALENZUELA. Well what I would like to see, I would like to see rather than a wide-ranging comprehensive change to the health care system, I would like to see you pick and choose certain programs that are existing that are working that are viable, and maybe perhaps encourage those programs to be expanded. And I think one of those is the Medicaid managed care plan, not only in Florida but in other States as well. And I will use an example of

Tennessee and their TennCare initiative, which was a plan to put all their Medicaid recipients into managed care, lock them in for a year and then with the savings increase the benefits to those uninsureds which do not qualify for Medicaid, but work for a small employer that cannot afford to have insurance, and they could buy into the program at a reduced rate. I think expanding the accessibility and the availability of coverage by increasing managed care's role and combining that with a government program that already exists, which is Medicaid, I think you can make a lot of important advances in providing care and accessibility to all Americans.

Mr. MICA. One last question if I may, Mr. Chairman. What kind of other waivers do you see, requests coming from Florida?

Mr. KELLEY. Well we have a major waiver that is really about 20 something waivers, but what it would do would be to take our savings from managed care, from putting the rest of the Medicaid population in managed care, and expand—and along with four other revenue sources in Florida, budget neutral for both the State and Federal Government, increase enrollment of the uninsured by a million people over the next 2 years on another benefits plan. So in other words, our proposal will take savings from managed care, savings from disproportionate share program, some State budgeted savings from interprogram transfers, and serve an additional 1 million people. That is what is in front of the Florida Legislature now and what has been sent to the Health Care Financing Administration by the Governor.

Mr. MICA. What percentage of Florida's uninsured will that cover?

Mr. KELLEY. There are 2½ million uninsured, so I guess it would be——

Mr. MICA. A little less than half.

Mr. KELLEY. Correct. And that's a voluntary program.

Mr. MICA. Thank you, Mr. Chairman.

Mr. TOWNS. Thank you very much. Let me thank all of you for your testimony. I think you have been extremely helpful, and as we move forward to deliberate in Washington, DC with this new proposal, we will keep a lot of these things in mind. Thank you very, very much.

At this time, I would like to call the next panel. Ms. Damirgian, who is a senior litigation counsel—come forward.

And I would like to yield at this time to the Congresswoman from Florida to introduce the other witness.

Ms. MEEK. The other witness, Mr. Chairman, is Ms. Georgia Ayres who is in charge of an alternative to incarceration program and she is coming before the committee this morning to represent the other side of this spectrum. We wanted the committee to hear something from the victims. She has worked for many, many years with that segment. You alluded to it in your presentation and I wanted Ms. Ayres to be here to give the committee some of her insights over the years in dealing with the Medicaid population.

Thank you, Mr. Chairman.

Mr. TOWNS. Why do you not go first, Ms. Damirgian.

STATEMENT OF JEANNE K. DAMIRGIAN, ASSISTANT U.S. ATTORNEY, SENIOR LITIGATION COUNSEL, SOUTH FLORIDA DISTRICT

Ms. DAMIRGIAN. I had asked to speak—I recognize I am not on your program this morning. I am here because the U.S. attorney's office here in Miami learned yesterday that there would be hearings on Medicaid fraud and that is pretty much all that we had heard.

I think one of the things that I would just like to update you on—I listened to the report this morning, I have worked very closely with Whiddon and with John Morris. The only thing I think you need to be updated on are what has been happening in terms of enforcement down here and in terms of our programs. One of the problems, I am sure you recognize is GAO has auditors or accountants that are sort of always behind us.

There has been a commitment by this U.S. attorney's office since the fall of 1990, and contrary to the GAO report, there has been at least one full time assistant, which was me originally and still is me, since the fall of 1990. In the spring of 1992, we added another assistant full time, and at this point we have seven part time assistants and two others working full time just on Medicare and Medicaid fraud. I do not have to tell you, we have that much fraud in south Florida.

One of the other things, most of our focus or most of our dollar loss down here is Medicare, at least for south Florida. But one of the very conscious decisions that was made right from the beginning was that we were going to reach out to the Medicaid fraud people here in Florida because, you know, common sense tells you if word gets out to the crooked providers, oh, the feds are now chasing Medicare fraud, they will just switch over and hit Medicaid heavier. And so we have done that very, very consciously.

One of the questions your panel asked this morning of John Morris was whether that 71 month sentence a week ago was the first or an exception. It is simply the last. Beginning in January 1992, with a minimal 10 months sentence, we have been sending doctors away down here, we have been sending health care providers away, who have been ripping off the system—I mean, it is a way of doing business in south Florida, and it does not matter whether you are talking about south Miami, Westchester, Liberty City. It makes no difference. They steal us blind.

The case last week where the defendant got 71 months, the facts in there, or the figures that you heard this morning were that the claims were $350,000. We convinced the Federal judge that, under the sentencing guidelines, he could look at all of that man's relevant conduct, which included not just what he was formally charged with but all the other thievery he did, either at that time and even while he was on bail, and that is why he is going to sit, and those 71 months are real time because, again, it is a guideline sentencing. That was a straight Medicaid case, Medicaid was the only victim.

We have had other cases. we had the infamous Sergio Bravo. The State chased him, DPR chased him for years. He is now doing Federal time on a joint Medicaid/Medicare case.

Next Tuesday morning, Eva Campis—she got $800,000 out of the Medicare program in 15 months, March 1992 until about June 1993. She was only able to get $150,000 out of Medicaid. On Tuesday morning, she goes before Judge King and she pleads guilty to ripping off both systems.

Again, we have finally gotten to the point where these cases are coming under the guidelines and our judges do not have any choice. They cannot do the old "there but for the grace of God go I," they have to send them away. Part of our focus—you know, we would like to focus more on restitution. The reality is when you look at a lot of the crime in south Florida, you have companies that are thoroughly corrupt. You do not have necessarily major companies or big companies that have a bad division where you can focus on restitution. You have companies that come in. They bang Medicare. They bang Medicaid. They are only in business for maybe 4 or 5 months. They steal somewhere between $300, $500, $600,000 and then they are out. And as the gentleman told you this morning, they are just reborn again the next week. You will have the same provider. He goes from being, you know, the ABC Corp. to being the XYZ Corp. If he gets caught and he gets taken into State court where, because of what they look at, nothing happens to anybody. I think we all know that. Then his wife opens the company and the whole process starts again.

You know, if someone were to say to me what is the single first step we can take to make a difference, I think the single first step has to be the single first step that the provider takes, whether that is Medicaid or Medicare. I mean you must have heard this so many times by now, but I am going to come back to it. Any time you can just get a provider number by sending in a piece of paper that has what you purport to be your name, that has a post office box—how many people live in a post office box? No one ever has to go out and verify that there actually is a business at this particular address and that this business actually has this product or this service that they are providing. And again, this is true as to Medicare as well as to Medicaid.

They were telling me, and I did not hear it this morning, but I tend to credit it, that somebody up in Tallahassee not too long ago decided to look at the recent rash of applications for Medicaid numbers, went out and satisfied themselves that 75 percent of those applicants, when they checked the address, there was no physical commercial establishment, that what there was was a mail drop, a post office box or somebody's third floor apartment.

I realize my time is up here I guess. But again, one last thing if I could. You had asked specifically what the other districts are doing and we are working closely with the other districts. I mean we have a task force here in south Florida which includes all of the Federal agencies with an interest in Medicaid Fraud Control Unit. The other districts, believe it or not, and particularly the northern district, Tallahassee, is trying real hard to gen up cases, but one of the things that keeps coming back is that you have got the worst of the providers in south Florida. So at this point, in order to literally generate business, Tallahassee has called our office and said look, here is a list of providers, you know, they have secondary venue because they pay tax in Tallahassee and so that—I mean

they are trying, we are trying, and I just did not want you to leave Miami without knowing that.

Ms. MEEK. I really thank you.

Mr. TOWNS. Thank you very much for your testimony.

Ms. Ayres.

STATEMENT OF GEORGIA J. AYRES, ALTERNATIVES TO INCARCERATION PROGRAM

Ms. AYRES. Good morning. My name is Georgia Ayres, I am founder, executive director of a program called the Alternative Program. When I sat and listened to you talk about having alternatives to incarceration for those persons who have committed the fraud, I had to smile about that because back in 1982, when the auditor general sent out about 300—I think it was exactly 321—warrants to arrest women for fraud, and it was welfare food stamp fraud, I became alarmed so much to the extent that I called Mrs. Reno's office and asked what the hell was going on, and I was told that the system wants to recoup its money from those persons that were committing fraud. And I am pleased to know that you are doing something other than just talk for the poorest of the poor, that is the women—let me back up. That morning when I got to the jail—by the way, I have complete access to the entire criminal justice system here in Dade County and I did not get it because they wanted me to have it. I had to fight like hell to get it, so much so that they said we might as well let her in, we cannot beat her, so let us join her.

The morning of the arrests back on October 2, 1982, I got a call from a mother 6 a.m., that the police were there to arrest her. I said, "What for?" And she said it was for fraud and the fraud happened back in 1975 when her husband was incarcerated and she was receiving food stamps. I recently found out that food stamp is really a Federal subsidy and welfare is State. However, I have made it possible for better than 2,000 or 3,000 people to be diverted from the criminal justice system into a program whereby I finally got our State of Florida to accept the process that I set before it, where the police department gives those warrants for fraud cases, welfare fraud, unemployment fraud, and food stamp fraud cases, I get those. I actually have the judges' proxy to go out and help these people—if the warrant is issued, they go to jail but I have the judges' proxy to sign them out of jail, put them in a program whereby I put them on a certain timeframe of paying that money back to the system. And I am proud to say within the past 2 years, I have sent back $100,000 to the State of Florida where persons have been overpaid—you all call it fraud, I call it overpayment.

I would like to see some sort of program initiated for those persons who are stealing millions—one of you said put them in jail and here in the State of Florida with the crime rate that we have, I would like to see persons charged with nonviolent offenses come out and serve their time doing community service hours in addition to paying back that money, rather than taking up that space in jail where we need to keep violent criminals.

Thank you.

Ms. MEEK. Mr. Chairman.

Mr. TOWNS. Ms. Meek.

Ms. MEEK. I was very interested in Ms. Damirgian's testimony because it was so truthful in the fact that she is calling your attention to the real fraud that exists here in south Florida. This Medicaid program and Medicare is almost a relief act for these criminals who come to south Florida for the sunshine and set up shop here. So I am so glad you brought that to the attention of the subcommittee. It is so important that something be done to stop this. And the fact that the Federal Government, particularly the U.S. attorney's office, has put that on their list of priorities, hopefully it will get a little more attention and you will get more people to work with you in that regard, it is extremely important.

And Ms. Ayres, I need to know from you in terms of what you see when people come to you complaining about these Medicaid doctors. They go from one to the other trying to get treatment and many times they are provided—prescribed so many different kinds of treatment and many times do not even get treatment. That is what I want you to tell the committee.

Ms. AYRES. Congresswoman, I have had the experience of a personal problem with my son-in-law, he has now passed, but he was in the hospital for 1 month and his bill was $50,000 just for the hospital alone. When I went through the entire bill, I found more fraud there than I care to remember. I did make several calls but I was told to call back, and since he had passed and could not speak for himself, I just left it alone. The hospitals are ripping you off 3 times as much as the doctors are ripping you off. So it is not just the doctors themselves, it is to the point—well I can give you an example. A box of Kleenex, and you know the hospital gives you very small boxes of Kleenex, a box of Kleenex, $2.50 and you know that is ridiculous. You multiply the number of patients any hospital has and if they are charging $2.50 for a box of the cheapest, because the Kleenex are very small—that is just one issue that I took issue with. And there were other factors in there, medicine that I asked him did they give you this, he said no, and the medicine that they had given him, I had a box full of pills that he never touched that they prescribed for him. I did make some calls about it, but as I said, I talked to his attorney and he said, "Georgia, there is nothing you can do about it because he is deceased and they will want to see the patient themselves."

Mr. TOWNS. I yield to Congressman Schiff.

Mr. SCHIFF. Thank you, Mr. Chairman.

I just feel like I want to say amen to the testimony of both witnesses, with one possible exception, and it may be just a semantic difference, Ms. Ayres. And that is when you say that you believe that nonviolent offenders, we should look for alternative sentencing rather than prison. I agree with that as a generality, but it seems to me that there are cases, and particularly those who nonviolently, if I must acknowledge, plan to raid the system for hundreds of thousands or millions of dollars, that it is my belief that you cross a threshold where the society has to say you are past doing community service at the local animal shelter and you are passed us waiting around for you to make restitution on that, we expect you to go to prison as punishment for that. And I hope you are in agreement with that, I hope I did not misunderstand.

Ms. AYRES. I will go back into the early 1970's when Dade County had a welfare queen. When she was arrested, she called me for services. I emphatically told her, "Baby, I do not help folk like you" because she was going from center to center frauding. People like that, no, I firmly believe that they should go to prison. But let us look, the welfare queen did not have a skill other than being shrewd enough to rip off the system, but a doctor does have a skill. I would make that doctor go into some hospital and perform his work. If his family wants to keep him home at night with them, fine, let them pay all the bills or whatever, but make that doctor go into some of these facilities, come to my center, come to any of the Head Start centers and give some form of service because he is a person that is qualified.

Mr. SCHIFF. Well let me just say I think we agree it is where you draw the line.

Ms. MEEK. Yes.

Mr. SCHIFF. I certainly agree that, again as a general principle, people who commit crimes, I think we should look for other kinds of approaches for what they owe society, and I do not disagree with you that someone who has a skill, we should look to use that skill, but there is a certain point where I feel that because you have a skill and you are ripping us off, rather than going to a 7–11 with a gun in your hand, you are ripping us off because you have the skills to do it, and although less violently dangerous, more economically dangerous—there is a certain point where I simply feel that we say what you are doing to our society is so horrendous, we want you to sit in a prison to recognize that you are a criminal too. And I think we have said the same thing here, it is just a matter of trying to find the line here.

I thank the panel very much and I yield back, Mr. Chairman.

Mr. TOWNS. At this time, I yield to Congressman Mica.

Ms. AYRES. May I say to you, sir, I believe that I put my own son in prison.

Mr. TOWNS. I think you made your point.

Mr. MICA. I appreciate you coming and providing this testimony today.

I have only known about what is going on here for the last 6 or 8 months, maybe less, and you know, I view it as really the silent scandal in our State and in south Florida. If you stop and think, you know, if people had gone into a bank and robbed $800,000 or $150,000, it would be on the front page of the paper tomorrow. Not only are they robbing the system, but they are also depriving people that need the care. This is an incredible situation.

Now my whole intent in trying to raise hell about this is to try to get the resources to those of you that are involved to correct the system. Now maybe we are in the process of shifting to managed care and we need to be looking at what the vulnerabilities of that system are, so people are not ripping us off with a new set of schemes. So my interest is, you know, are we providing the resources from the Federal Government. Our committee—you know, we can call Janet Reno, we can call—we can bring this to the attention of whoever, or look at the appropriating committees to see that you have the resources to correct this.

So we are trying to do this in a constructive method and also with Florida being one of the top two, three in the Nation and south Florida is right there. But nobody seems to care, you know—nobody seems to care.

Now you are doing a great job from what I understand with limited resources. This should really be a question—what else can we do?

Ms. DAMIRGIAN. If I had my wish No. 1, and if you had any drag with the Health and Human Services, we would have more Health and Human Services investigators. We have four for all of south Florida, three of whom do health care, one of whom does social security. Until last August we only had three, last August they shipped a fellow over when they closed down the Puerto Rico office. He is the first Spanish speaking HHS agent in the State of Florida, period, ever.

Now how anyone can figure out how to do health care investigations in Dade County without having Spanish speaking HHS agents is a mystery to all of us. We do have assistance from the FBI. When they gave up the terrorists or whatever they did, they shipped more men into health care. And they are fine, they are bodies. But when it comes to the actual expertise, the going through the paper, the knowing what to do, we need HHS agents, we need them desperately.

Besides the criminal focus—and it is sort of interesting because the managed care people are talking about yes or no, more investigators, we need more investigators because we have also concluded—you know, it takes a long time to make the perfect criminal case, reasonable beyond a doubt. By then they have ripped us off through two other companies and moved on to someplace else. So we have a whole civil unit in the U.S. attorney's office in addition to the nine of us doing criminal. Right now, we have a TRO that we have obtained against a Medicaid provider down here who had billed you all for $4 million, and we have stopped him. So I mean, we know how far behind the ball we are, that we are going at them civilly, we are going at them criminally.

But you know, some help from HHS would be wonderful.

Mr. MICA. Statutorily, do you have enough——

Ms. DAMIRGIAN. Statutorily, realistically we are fine.

Mr. MICA. It is primarily resources. And the attention that we have sort of raised preliminarily, is there enough attention being focused? I mean, are they in fact giving you the resources you think you need or is this just a show?

Ms. DAMIRGIAN. Justice is—I do not know if it is official or rumor at this point, but apparently there are going to be instances where they are going to divert some of the FIREA, the financial institution resources, over to do health care. So if that goes through the way we suspect it will soon, we will get more resources—translation, assistant U.S. attorneys and FBI agents. And we are all real dedicated, but it is still—you know, again, I know nothing of politics but this is HHS' bailiwick and we need them. We need somebody that can look at a cost report, because what Ms. Ayres was saying about hospitals, you are looking at a whole special animal in the health care fraud business, you are looking at part A pro-

grams. We need help, we need that kind of specific expertise that can really do health care fraud.

Mr. MICA. I welcome either of you communicating with me or the committee or Ms. Meek as we go through this. You know, it has been just 5 or 6 months since we have gotten involved in this, we want to make sure it is cleaned up and then as we go into—we are going into a new phase in the next 24 months here, there will be new people figuring out new ways to rip off the system. And we cannot, you know, concentrate on every box of Kleenex, but we can—you know, you can get the people that are ripping off the huge chunks of money and bring that to an end and then provide the services to people.

There are a lot of people that need health care services in south Florida, in the State and the country. And if the money is being siphoned off by criminals or criminal schemes, we need to stay a step ahead of it.

I thank you so much, both of you, for your positive contributions today. Thank you, Mr. Chairman.

Mr. TOWNS. Thank you. I did not have my round yet.

First of all, let me thank both of you for your testimony. I think that it is so important because you have some information that we could use nationally because of you being involved here with managed care, you know, now for quite sometime, more than most States and most areas. And I think that we can learn a lot from you as a result of that kind of involvement.

I was talking earlier about the fact that what we probably will see now is a shift in terms of the fraud, the fact that before it was overbilling and now it will probably be under—whatever comments or suggestions that you have for us along those lines, I would like to leave the record open for any comments that you might want to have that we could share with others as we begin to look at what we might need to do to make certain that people are protected. I think that is the key, because there seems to be a lot of waste and I think that we need to do something about it. So I would like to just leave the record open for X amount of days just for additional comments that you might have for us, you know, in that regard.

And the other part I would like to raise with you, which is a problem in a lot of areas of the country—I do not know whether you see it here or not, is that law enforcement officers have a tendency to get in the way of each other. What I mean by that is we had a situation in New York that was so awful wherein one law enforcement person locked up another one, they were both investigating the same case and they were—finally one locked the other one up and they find out that they all were doing the same thing, working on the same—which ended up being a waste of a lot of resources.

So how do you avoid that kind of thing here in terms of your investigations when they are moving forward, to make certain that you do not have every law enforcement agency and everybody working on the same thing at the same time?

Ms. DAMIRGIAN. One of the things, again—and I go back to Philadelphia where we had something called the insurance fraud task force. When I came down here we started what is called the south Florida health care fraud task force, something like that. And es-

sentially what we do is about once every 2 or 3 months, we bring everybody in to one of our conference rooms at the U.S. attorney's office, you have got the FBI, you have got the U.S. Postal Service, the Medicaid Fraud Control Unit, anybody that is really seriously looking at health care fraud. In the beginning, we had division of insurance fraud, but I think they have with FEMA or with the hurricane, they sort of went the other way. And we sit down and we discuss amongst each other what are you looking at, where are your problems coming from, who is giving you problems. So that at least we, within the health care fraud network are talking to each other, we are not running in undercover operatives against each other.

Our contacts with the police department have been more limited, they are not an active part of the task force, but every person on the task force has liaison with the local police departments and it has paid off beautifully. For instance, we got a call from a police officer in Miami Beach PD; you know, he said, I ran into something, I am not sure what is going on here, one of my drug snitches tells me this and that. They were talking about Medicaid and Medicare fraud. I do not know what to do with this, but I was told call the U.S. attorney's office or call Medicaid Fraud Control Unit. And so we get great cooperation, we get it from Metro Dade, we get it from Miami PD, Miami Beach PD, so that we do not have this problem so far.

Mr. TOWNS. Ms. Ayres.

Ms. AYRES. In my instance with the fraud cases, I met with all of our local police departments and it is a standard procedure in Metro, if you arrest someone with any of those warrants, they will tell you to call the alternative program. I have meetings periodically with our State attorney's office and people from our local auditor general's office here in Miami.

Mr. TOWNS. Thank you very much.

And let me just sort of clear up one other thing before we just shut down here. GAO did acknowledge the fact that there has been a tremendous improvement, and of course they indicated that their study was back some time ago, but as to what they have observed at this point, there has been improvement in this area. So I think we need to indicate that as well.

Ms. DAMIRGIAN. Oh, I understand that, and I mean even with things like this drug diversions, we do them when we get them, we were part of operation voltel out of New York where we put—we did not put them in jail, we knocked them out of business, eight or nine pharmacists from Broward County. And now—I do not know if you all know this, but now the Food and Drug Administration is in the health care fraud business.

Mr. TOWNS. Yes.

Ms. DAMIRGIAN. So now we have 12 of them, they are based in Miami, so now you will see more drug diversion.

Mr. TOWNS. Again, thank you both for your testimony.

Mr. MICA. Mr. Chairman, before you adjourn, just one comment. I want to take a liberty, and again, I cannot thank you enough for taking time, you—you know, you have wonderful family and you, Mr. Schiff, family, to come from New York. We did not have votes today, they could have been back with their constituents and fam-

ily and friends, but you did—I was raised in this community, it is a wonderful community, I live in central Florida now, but I think it was so important that we focus on this and have these people together, because you have the attention of the State leaders and you have the attention of the people that are involved in the program, so I commend you on coming here. I know you came in late last night, we have got to leave right after the hearing, but I want to welcome you back to Florida sometime when you can stay. But I tell you, I sincerely appreciate this. On behalf of myself, the other members of the delegation that care about this matter, and I know Congresswoman Meek shares my invitation to return here. We are so grateful. Thank you.

Mr. TOWNS. Thank you so much. We certainly appreciate your kind words and also the invitation.

The Committee on Government Operations hearing on Medicaid fraud has been concluded.

[Whereupon, at 12:50 p.m., the subcommittee adjourned, to reconvene subject to the call of the Chair.]

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